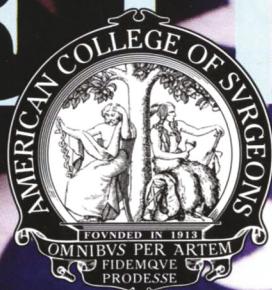


BULLETIN

AMERICAN COLLEGE OF SURGEONS



April 2001

Volume 86, Number 4

*Health care
policymakers
in Congress*

BULLETIN

AMERICAN COLLEGE OF SURGEONS



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About the cover...

When the 107th Congress chose its leadership earlier this year, some significant changes were made within the major House and Senate committees that have jurisdiction over health care issues. "Key health policymakers in the 107th Congress," p. 16-22, introduces to Fellows the new chairs and ranking minority members of these committees—the House Ways and Means Committee, the House Energy and Commerce Committee, the Senate Finance Committee, and the Senate Health, Education, Labor, and Pensions Committee. The article is intended to help Fellows become more familiar with some of elected officials who are crafting legislation that will affect their patients and their profession.

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From my perspective

As everyone who practices surgery today realizes, the legislative and regulatory issues affecting our profession are overwhelming, and any efforts to resolve these matters have proven to be complex. Therefore, surgeons in all specialties need to work together to determine how and why our current problems arose, which ones can be managed, and how the surgical community can contribute to improving the future of patient care.

Recognizing that the health policy issues before us call for a proactive stance, as well as cooperative yet forceful and swift reactions, the College has formed a new Regental Health Policy Steering Committee, which is working closely with the College's Washington Office. It is our vision that this committee will respond in a timely fashion to issues that are of importance to all of surgery so that we can speak with a unifying voice for our patients.

Critical health policy issues

The issues confronting us today are many and extremely complex, and they evolved over a long period of time. Reimbursement problems came to the fore in the early 1980s, when the prospective payment system was developed to pay for hospital-based Medicare services. Subsequently, the resource-based relative value scale (RBRVS) was devised as the basis for determining payment for physician services rendered to Medicare patients. The RBRVS led to payment reductions for surgeons and forced the College to focus much of its advocacy power on reimbursement issues.

Along with Medicare reimbursement, health care reform has been the subject of contentious debate in Washington, especially since the Clinton Administration offered its ambitious overhaul plan nearly eight years ago. That proposal, of course, was shelved in 1994 after heated debate, leaving the free market to be the dominant voice of change since that time. Managed care organizations have absorbed the bulk of patients who receive coverage through the workplace, yet we still must contend with the daunting problem of 43 million people being uninsured in this country. Meanwhile, we cannot even say that managed care has controlled the



“We anticipate that our Health Policy Steering Committee will assist in formulating an advocacy agenda that is patient-focused, unifying, and doable.”

cost of medicine, as the nation's employers are likely to face two-digit annual increases in their health care bills.

Further, the government has continued to enact laws and accompanying regulations to the point where the complexity of practicing medicine today is mind-boggling. For example, the Emergency Medical Treatment and Labor Act (EMTALA) has resulted in the imposition of unrealistic on-call requirements, and the Health Insurance Portability and Accountability Act (HIPAA) led to, among other concerns, the creation of a flurry of anti-fraud and abuse rules and new regulations affecting the use of information contained in patient medical records. In other words, some well-intentioned laws led to the imposition of regulations that are simply stifling and impractical given our current resources (they are approved but not funded).

Additionally, we must contend with waste in our medical system and the fact that frequently the value of the end medical "product" may not

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always meet expected standards. Thus, we face additional pressures generated as a result of reports issued by groups such as the Institute of Medicine, which point to errors and other problems within our systems of delivery.

Policymakers in Washington are receiving input on these issues from an array of stakehold-

ers. Competing organizations—such as those representing patients, hospitals, and pharmaceutical companies—are all actively lobbying for their own special interests. At the same time, employers are very vocally expressing their concerns about the cost of medical coverage, which comprises a staggering amount of their budgets.

The committee

So, now more than ever, the College needs a group of knowledgeable, concerned surgeons to work on health policy issues. This group should help us move our focus away from the divisiveness that has often hindered progress on payment issues and refocus our political energies on patient welfare and other matters that ally surgeons and are on the front burner for Congress. Not all of the issues can be resolved, but we anticipate that our Health Policy Steering Committee will assist in formulating an advocacy agenda that is patient-focused, unifying, and doable. Setting a feasible agenda will be key as we become a more proactive organization.

The Health Policy Steering Committee is chaired by Josef E. Fischer, MD, FACS, of Cincinnati, OH. Representatives from a broad spectrum of surgical specialties and demographic groups serve on the panel. To ensure that we can go forward as an integrated body representing not only surgery but other medical disciplines as well, surgeons with close ties to the American Medical Association, the specialty societies, and other organizations also have seats on the committee (see roster, p. 5).

The committee held its first meeting in February and was very productive. Topics discussed at that time included those related to patient safety, collective bargaining, EMTALA, graduate medical education, physician workforce problems, and managed care reform.

Looking ahead

With the number of issues and challenges facing the medical profession, it is of the utmost importance that the surgical community and especially the College reconsider its political goals. Are we going to make small, incremental changes, or is the health care system ready for major systemic change? Are we going to accept only piecemeal changes, or are we prepared to accept fundamental restructuring?

As a College representing all of surgery, we need to have a say in the debates of the 107th Congress and into the future. Our new Regental committee is another example of how the College is attempting to unify all components of surgery such that we can have a proactive and timely voice in setting a tone and an agenda with regard to health care.

I invite all of you to help the College formulate appropriate goals and responses for the future. Your input will assist me and the members of the Health Policy Steering Committee to in forging policies and plans for the future.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

FYI: *STAT*

T*his column provides brief reports on important items of interest to members of the College. It will appear in the Bulletin when there is "hot news" to report. In-depth coverage of activities announced here will appear in columns and features published in the Bulletin and in the College's weekly electronic newsletter, ACS NewsScope.*

- ❖ ACS Executive Director Thomas R. Russell, MD, FACS, traveled to Washington, DC, last month to: meet with Greg Ganske, MD, FACS (R-IA), and Bill Frist, MD, FACS (R-TN) on March 14 to discuss **patients' rights legislation**; represent the College, along with Kurt Newman, MD, FACS, the ACS appointee to the **National Committee for Quality Assurance's** (NCQA's) practicing physicians advisory committee, at a March 6 event to commemorate (NCQA's) 10th Anniversary; and participate in the American Medical Association's 2001 **National Leadership Conference** on March 3.
- ❖ Fellows and Associate Fellows can now participate in the *Journal of the American College of Surgeons Online CME-1 Program* and earn up to two CME Category 1 credits each month. Visit <http://www.jacscme.org> to read each month's designated articles and participate in an exercise in which you evaluate relevant clinical material from the article and apply it to clinical practice. This program is a membership benefit, so you will need to use your Fellowship identification number to access it.
- ❖ On March 23, Dr. Russell hosted a **meeting with representatives of the surgical specialty societies and the ACS Advisory Councils** to discuss a variety of issues affecting all surgeons. Among the topics discussed at the Chicago-area meeting were resident work hours, the Emergency Medical Treatment and Labor Act, Medicare reform, and other issues.
- ❖ Edward E. Cornwell III, MD, FACS, chief of trauma services at the Johns Hopkins Hospital, recently testified before Congress on behalf of the College in support of **federal funding for trauma system development**. See "Dateline: Washington" on page 8 for details.
- ❖ The 2001-2002 edition of the College's **annual Publications & Services Catalog** is being mailed to Fellows this month. The catalog contains more than 100 titles published by the College on a wide variety of topics that reflect the diversity of clinical and current issues facing today's practicing surgeon. An online version of the catalog—complete with a secure order form—can be viewed on the ACS Web site at www.facs.org.

Dateline|Washington

prepared by the Washington Office, Health Policy and Advocacy Department

ACS testifies in support of trauma system funding

On March 13, Edward E. Cornwell III, MD, FACS, chief of trauma at the Johns Hopkins Hospital, testified before the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, to request \$6 million in fiscal year (FY) 2002 to fund the Trauma Care Systems Planning and Development Act. The primary purpose of the program is to provide grants to states so that they can plan, implement, and develop comprehensive trauma care systems. Congress approved \$3 million in FY 2001 for the program.

In his testimony, Dr. Cornwell highlighted the findings of a 1998 academic conference on trauma systems. The so-called Skamania Symposium featured an update on U.S. trauma system development, based on the results of a 1998 survey of state emergency medical service (EMS) directors. While the results of the survey found that only five states met all eight key trauma system criteria, it also showed that 28 states reported meeting six or seven of the key criteria—a significant improvement over a similar survey conducted in 1993. In addition, Dr. Cornwell discussed efforts under way at the Health Resources Services Administration (HRSA) to use current funding to conduct a survey of state health departments to assess the effectiveness and capabilities of each state's trauma and EMS systems. The full text of Dr. Cornwell's statement may be viewed on the College's Web site at <http://www.facs.org/dept/hpa/testimony/trauma2001.html>.

Physician relief and education package introduced

In early March, members of Congress introduced a bipartisan proposal known as the Medicare Education and Regulatory Fairness Act (MERFA). The legislation was introduced in the Senate by Senators Frank Murkowski (R-AK) and John Kerry (D-MA) as S. 452, and in the House by Representatives Pat Toomey (R-PA) and Shelley Berkley (D-NV) as H.R. 868. Sponsors on both sides of the Capitol consulted the physician and hospital communities extensively in designing the regulatory relief and education package.

The bill proposes to make the claims auditing and overpayment recovery processes more reasonable by prohibiting Medicare carriers from: conducting prepayment audits of physician practices without cause, recovering past overpayments while an appeal is pending on a disputed claim, extrapolating alleged overpayment amounts to other nonaudited claims when reviewing a practice for the first time, and conducting indefinite prepayment review of physician practices once they have resumed submitting properly coded claims. MERFA also requires carriers to set up reasonable repayment plans for physicians whose overpayments have been confirmed and to cooperate with health care associations to create educational initiatives for physicians about coding and documentation guidelines.

New IOM report on quality released

On March 1, the Institute of Medicine's (IOM's) Committee on the Quality of Health Care in America released a new report entitled *Crossing the Quality Chasm: A New Health System for the 21st Century*. The report is the final installment in a series that included the highly publicized 1999 report *To Err Is Human: Building a Safer Health System*.

The new quality report contends that the American health care delivery system is in need of fundamental change, and it sets out a series of recommendations that challenges physicians, hospitals, health plans, purchasers, and others to work toward improving health care quality. In particular, the committee offers 10 new "rules" intended to make the health system more responsive to patient needs and preferences and to encourage their participation in decision making. It also calls on Congress to establish a \$1 billion "Health Care Quality Innovation Fund" to help subsidize promising projects and communicate the need for rapid and significant change throughout the health system. The full text of the report can be found on the Web at <http://www.nap.edu/catalog/10027.html>.

ACS urges level playing field in Patients' Bill of Rights

The issue of health plan liability continues to be one of the major stumbling blocks to enactment of a Patients' Bill of Rights. The American College of Surgeons weighed in on this issue with a letter to President Bush, urging him to ensure that any Patients' Bill of Rights that ultimately is enacted creates a truly level playing field with respect to liability exposure for physicians and health plans. This is the same message the College sent in a letter to key Senators and Representatives last year.

In early February, Sen. John McCain (R-AZ) and Rep. Greg Ganske, MD, FACS, (R-IA) introduced the "Bipartisan Patient Protection Act of 2001." This legislation addresses many of the issues that were included in a bill the College supported last year, such as an independent external appeals process, access to specialty care, and a ban on "gag clauses." A major difference, however, is the inclusion of a \$5 million cap on punitive damages for health plans. Some members of Congress have also proposed capping noneconomic damages when malpractice suits are brought against health plans. The College argued in its letter to President Bush that it would be unfair to enact a Patients' Bill of Rights that caps damages for suits brought against health plans without also capping damages for lawsuits brought against physicians, hospitals, and other health care practitioners and providers.



THE MEASUREMENT OF COMPETENCE

CURRENT PLANS AND FUTURE INITIATIVES
OF THE AMERICAN BOARD OF SURGERY

BY WALLACE P. RITCHIE, JR., MD, FACS,
PHILADELPHIA, PA

The measure of competence and the link between competence and certification have become major agenda items for every member board of the American Board of Medical Specialties (ABMS). This circumstance stands in stark contrast to the situation 10 years ago when boards confined themselves to their traditional but limited goals: to examine, to certify, and to improve the opportunities for graduate medical education in their respective disciplines. The reasons for this narrow view were quite valid (in fact, many of them still are): major definitional problems, major measurement problems, and major legal problems.

That stance is no longer tenable and the reason is simple: the pressure is on the boards to link possession of a certificate to competent performance in practice. The boards have always assumed intuitively that such a relationship exists but never put into place a concrete process for demonstrating it for the reasons enumerated. Now they must prove certification and competence are interrelated.

Three events stimulated this change of approach. First was the appearance of report cards from managed care organizations, which served to alert the public that comparative information was available about physicians and their practices.

The second was the American Medical Accreditation Program, a short-lived but highly publicized undertaking by the American Medical Association (AMA), which sought to accredit the adequacy of an entire physician's practice, including competent care. The AMA had made the right diagnosis—that is, that the public was anxious for assurances that the physicians caring for them are competent and, at the same time, physicians were anxious to demonstrate that fact. Unfortunately, the AMA had the wrong prescription; it involved itself in an irreconcilable conflict of interest by attempting to accredit its own members.

The final pressure was the publication of the Institute of Medicine report, *To Err Is Human*, which has caused incredible angst in the minds of the public and within the profession while arousing enormous interest among regulatory agencies.

Obviously, boards cannot be immune to this

phenomenon and must become deeply engaged. Not to do so would render their end product, certification, incidental at best and irrelevant at worst. Recognizing that risk, the ABMS three years ago created a task force charged with identifying those broad elements or domains by which competent physician behavior could be identified and measured. That task force outlined six primary components (see Figure 1, p. 12): (1) competent patient care; (2) adequate medical knowledge; (3) a lifelong commitment to evidence-based and practice-based learning, the endpoint being practice improvement; (4) interpersonal and communications skills; (5) professionalism; and (6) systems-based practice.

The task force launched one other very important initiative: it developed a related concept called maintenance of certification (see Figure 2, p. 13), roughly defined as evidence of continuous high professional standing, continuous commitment to lifelong learning and involvement in periodic self-assessment, continuous evidence of cognitive expertise, and continuous evidence of evaluation of performance in practice. What successful maintenance of certification signifies, in essence, is that those who hold a certificate possess at any given moment in time the same qualifications and have been subjected in an ongoing way to the same rigorous scrutinies that were possessed and scrutinized on the day the certificate was issued. The goal is to ensure that the certificate is and always will be closely linked to competent performance.

No board, including the American Board of Surgery (ABS), is under the illusion that creating this linkage will be easily or readily accomplished. There exist major issues and major problems that must be resolved and difficult questions that must be answered. These include:

- Are the listed competencies relevant to the disciplines of surgery?
- Are adequate assessment tools currently available? If so, can they discriminate?
- Most importantly, are they legally defensible?
- What will be the cost? Who will bear it?
- How can the board deal with the enormous heterogeneity of practice, especially in general surgery?
- What should be the endpoints?

- Where should the bar be set for decertification? Should there even be a bar?
- How can diplomate buy-in of the initiative be achieved?
- What is the value of the initiative to the practicing surgeon?

The magnitude of the task will become apparent when current and proposed approaches of the ABS to some of the listed competencies are examined. It will also become apparent that boards cannot undertake the task alone. They need the help of specialty societies and most importantly, for the ABS at least, the help of the American College of Surgeons (ACS). Specialty societies and the College have a large stake in this enterprise because they, too, need to forge links with the maintenance of certification effort if they want to remain genuinely relevant to their constituents. The problems and the importance of partnership are well illustrated by analyzing the ABS approach to three competencies in particular: cognitive knowledge, professionalism, and patient care.

COGNITIVE KNOWLEDGE

The one task that the ABS and the other surgical boards do indisputably well is create and administer sophisticated multiple-choice examinations. The current recertification examination is no exception; it is psychometrically sound, it is equated to past cohorts, it is peer-reviewed for relevance, and practicing surgeons are closely involved in its construction and oversight from the beginning. Most importantly, it has credibility with the public because it is proctored and secure and will continue to be so.

Despite these assets, the recertification examination in its present construct suffers from three limitations. The first of these is that the 10-year recertification cycle is far too long. A much shorter interval between examinations is needed in order to provide surety to the public that a diplomate is, in fact, current in the basic information requisite for the discipline. It seems likely that the ABMS will decide upon a much shorter interval than is currently practiced by most boards and, once that interval is defined, the ABS will support the change.

The second limitation is well recognized by

FIGURE 1

GENERAL COMPETENCIES

- Medical knowledge
- Patient care
- Interpersonal and communication skills
- Professionalism
- Practice-based learning and improvement
- Systems-based practice

Adopted by the ABMS Assembly on September 23, 1999.

diplomates who regularly complain that they are at a loss as to how to prepare for the recertification examination because there is no syllabus, no text, and no hint from the board as to either examination content or board expectations. The board recognizes that this debit must be corrected if the examination is to have value for diplomates. At a minimum, a core of knowledge has to be defined more explicitly than it is at present, a core that will represent the essential information everyone who holds the basic surgery certificate must master and continue to master regardless of practice type.

The board will take the lead in this defining exercise, but it cannot accomplish the entire task alone. The board must partner with the broader general surgical community, and the logical partner is the ACS. Once such a curriculum is devised, its essential elements must then be made widely available in a didactically sound way to diplomates and Fellows. There can be no better forum for providing surgeons with this knowledge than the annual Clinical Congress or perhaps the Spring Meeting of the College, using as a vehicle a specific postgraduate course devoted to the effort on a regular basis.

In that same connection, a major thrust of the maintenance of certification effort is to encourage diplomates to engage in the process of life-long learning—continuing medical education

FIGURE 2

MAINTENANCE OF CERTIFICATION: THE PROGRAM FOR ASSESSMENT OF CONTINUING COMPETENCE

Maintenance of certification is the board certification program for assessment of continuing competencies of physicians and encompasses recertification. Maintenance of certification has four basic components:

- Evidence of professional standing.
- Evidence of a commitment to lifelong learning and involvement in a periodic self-assessment process.
- Evidence of cognitive expertise.
- Evidence of evaluation of performance in practice.

Adopted by the ABMS Assembly on March 16, 2000.

relevant to their practices—and to provide them with the means to measure their own progress and to improve through self-assessment testing and feedback. No better instrument to accomplish this exists than some variation of the Surgical Education and Self-Assessment Program (SESAP), which focuses on the already-defined core. The board can mandate and reward that activity—in fact it already does—and the College can provide it if it has the blueprint. To put it simplistically, the College can teach and the board can test.

Similarly, the board and the College can and should partner in the effort to define periodically what is new, what is important, and what is enduring in general surgery. That having been done, the same profitable collaboration can exist: the College can teach and the board can test. Diplomates, Fellows, and the public will all benefit because in this way, a mechanism for ensuring relevant ongoing currency is always in place.

The third limitation to the current ABS recertification schema, perhaps the most impor-

tant of all, relates to the frequent criticism leveled that the examination is not testing diplomates in the area of their current practice focus and principal expertise. Absent that characteristic, the exercise has little relevance for many diplomates who view it as a chore to be accomplished, but one lacking in value because what it tests is often not personally germane. The issue here, of course, is value—the value of cognitive testing to individual diplomates. This is a fundamental issue because for the competence initiative to succeed, diplomates must be willing to buy in to it. If there is little or no value to the process, there is little or no buy-in. Many on the board believe it should address this issue by altering the structure of the recertification examination to recognize the incredibly diverse areas in which diplomates practice. That recognition having been attained, feedback can be provided to diplomates in the form of report cards that will allow them to judge for themselves where they stand with respect to their peers.

What all this speaks to, of course, is the development of a basic core modular recertification examination that all diplomates must take and pass, plus a menu of modules corresponding perhaps to the primary components of surgery as the board has defined them. From that menu, diplomates may choose one or perhaps several in their areas of expertise and interest.

There are questions, however, that the ABS must answer before modular testing becomes a reality. They include:

- How can the psychometric validity of the core be maintained?
- How should the modules be developed and used?
- How should they be scored?
- How should they be weighed?
- Most importantly, how can the board prevent the successful completion of a module from becoming a mini-certificate?
- Finally, there is the very special problem of general surgery, the practice of which is so extraordinarily heterogeneous that it may not be possible to create enough modules to cover every circumstance.

Nevertheless, the board is moving in this direction and with some rapidity. Once again, how-

ever, it will be necessary to partner with the ACS and with specialty societies, particularly with respect to defining the competencies expected within each of the modules and to developing a valid instrument for testing them.

PROFESSIONALISM

The second competency, professionalism, encompasses, among other qualities, high standards of moral and ethical behavior. The board already gleans much of the information needed to assess this competency through local peer review. However, the most important present source of this information is the AMA Physician Disciplinary Alert Bulletin, which regularly lists all adverse licensure actions for all ABS diplomates. On the thesis that an unbesmirched license to practice is the most basic characteristic of competency, the board pulses these data on a quarterly basis, paying particular attention to potentially egregious sanctions, such as revocation, surrender, suspension, or probation. The details are then investigated with each state board and, if the infractions are serious enough, the board has the option, following review by its credentials committee, of revoking a diplomate's certificate.

In addition, the board adopted, at its January 2000 board meeting, a much-expanded policy regarding certificate revocation. Decertification can now be invoked under the following circumstances: if the diplomate did not possess the necessary qualifications to receive the certificate in the first place, if the diplomate misrepresented his or her status relative to certification, if the diplomate sustained an adverse licensure action, if the diplomate was expelled or disqualified from membership in any professional organization of peers, or if the diplomate had major limitations placed on privileges to practice.

The principal limitation to this approach is that it identifies and sanctions only the outliers within the system, "the baddest of bad apples." The sad truth, however, is that the board has no choice in this matter because it would engender an enormous legal risk if it undertook decertification action based on anything beyond revocation or surrender of a license to practice or conviction of a criminal offense coupled with incar-

ceration. That is not to say that this approach cannot identify marginal practitioners; it can. At a minimum, then, it becomes the board's obligation to act as a probation officer in these cases and to mandate that problematic diplomates keep it informed on a regular basis as to the status of the sanction, recidivism, new problems, and so on. It may be of some value because the simple fact that the diplomate is aware of the board's interest may serve as sufficient impetus to reflect, perhaps even to change, behavior. Conscience, after all, is never so strong as when someone is looking over your shoulder.

QUALITY OF PATIENT CARE

It goes without saying that in a technical specialty the best approach to measuring the quality of patient care is to examine the end results achieved with specific procedures by individual practitioners—outcomes. The advantages of this approach are obvious: outcomes are definable; they are discoverable; they can serve as a surrogate for a host of other components of competence, including technical ability; and national norms for outcomes can be, and in many instances have been, determined. The difficulties inherent in outcomes assessment also are clear. Even though a plethora of outcomes assessment instruments is available, both commercial and otherwise, most are either very crude or very naive, or they measure the wrong endpoints (at least from the perspective of the competence initiative). Conversely, if they are not crude, if they are not naive, and if they do measure the right endpoints, they are enormously expensive to implement. General surgery in particular poses an especially troublesome difficulty for the board: the development of universally applicable outcomes analyses for a major constituency of the board whose practice profile is incredibly varied.

Despite these difficulties, the board believes it must begin the effort now. As an initial step, the board has developed preliminary guidelines for outcomes assessment:

- There must exist or the board must create a simple method for risk adjustment.
- Individual outcomes must be compared with valid national norms.

- The data must be easily collectible so as not to burden diplomates excessively.
- The endpoints selected must be few in number, easily measured, and clinically relevant.
- At least initially, the board should concentrate on short-term outcomes.
- The confidentiality of the results must be absolutely guaranteed.
- Most importantly, the rationale for the exercise must be clearly stated and strictly followed, namely that the data from individual practitioners will be used to provide feedback to them alone for the sole purpose of stimulating practice improvement and with no other endpoint in mind.

With these caveats, the board has been in contact with the vascular surgical community, the surgical oncology community, and the pediatric surgical community, inviting each to serve as testing groups to develop templates for the entire effort. All have indicated their enthusiastic support. Fortunately, each seems ideally suited to the role because the numbers of practitioners are relatively few in each group and their practices are relatively uniform.

Each has been asked to address many thorny questions, including:

- Which outcomes?
- Which endpoints?
- What methodology?
- How can improvement be measured?
- And, most difficult of all—perhaps unanswerable—how can the effects of the system be separated from the actions of the individuals?

There is a role for the College in this outcomes effort. The College has enormous creative energies that could very well help provide the needed support and infrastructure to assist in establishing a way to assess outcomes, particularly in general surgery. The College will also be a critical collaborator in the future assessment of technical competence.

SUMMARY

In summary, the ABS is committed to the competence initiative. Not to do so would be to risk irrelevance.

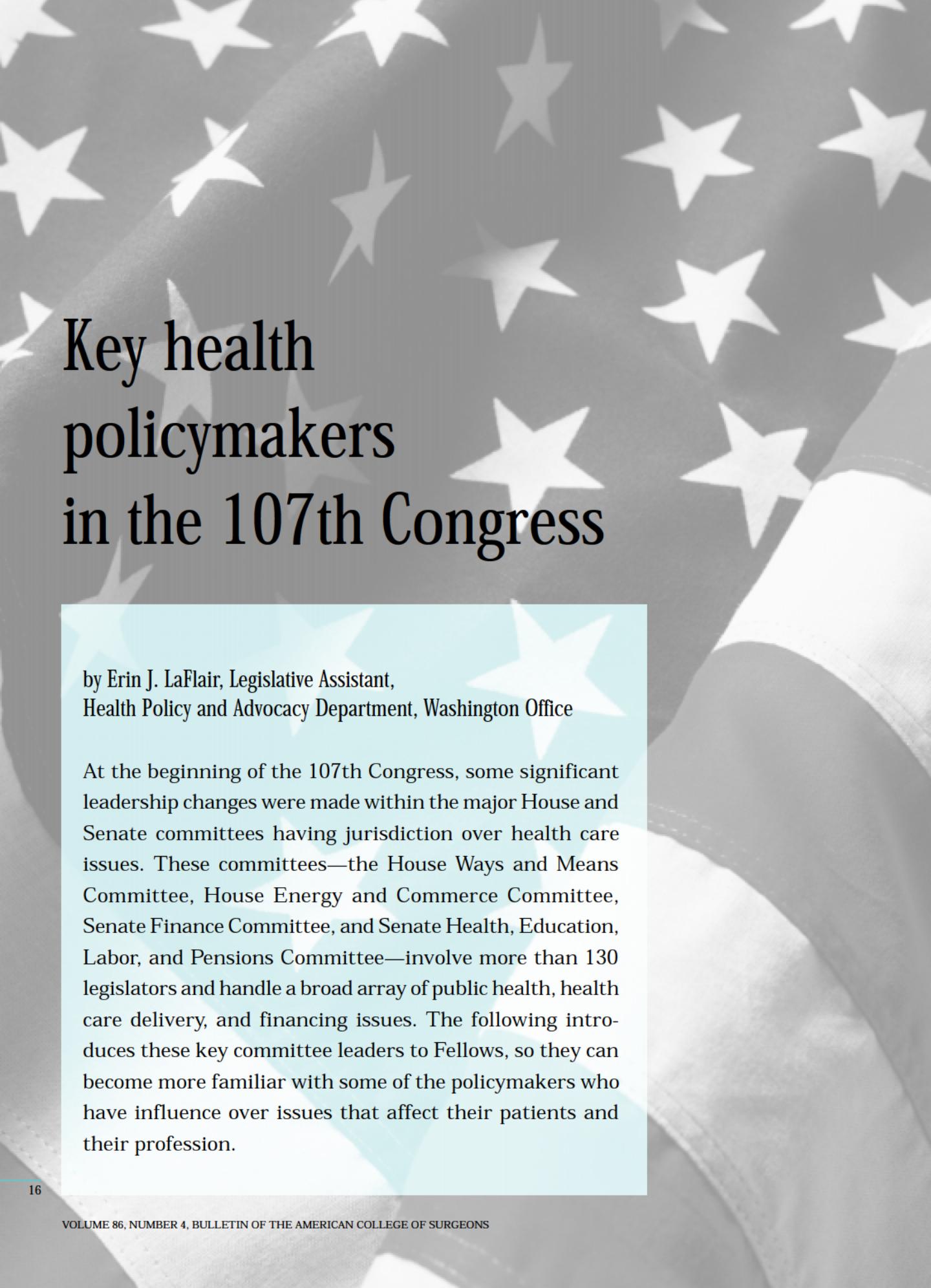
In order for the initiative to succeed, it is clear that the board must partner with specialty so-

cieties and most particularly with the American College of Surgeons. That partnership should take the form of collaboration to "teach and test" core information in general surgery and in the surgical specialties and to adjudicate appropriate risk-adjusted outcomes.

The aim of the initiative is practice improvement and practice improvement only. It is the hope of the board that diplomates and Fellows will see value in the exercise and will endorse it because of pride in their profession and pride in themselves. Ω

Dr. Ritchie is executive director and secretary-treasurer of the American Board of Surgery.





Key health policymakers in the 107th Congress

by Erin J. LaFlair, Legislative Assistant,
Health Policy and Advocacy Department, Washington Office

At the beginning of the 107th Congress, some significant leadership changes were made within the major House and Senate committees having jurisdiction over health care issues. These committees—the House Ways and Means Committee, House Energy and Commerce Committee, Senate Finance Committee, and Senate Health, Education, Labor, and Pensions Committee—involve more than 130 legislators and handle a broad array of public health, health care delivery, and financing issues. The following introduces these key committee leaders to Fellows, so they can become more familiar with some of the policymakers who have influence over issues that affect their patients and their profession.

House Ways and Means Committee

The House Committee on Ways and Means, the oldest congressional committee, has jurisdiction over tax measures, internal revenue service oversight, trade, and national trust funds, including the Medicare Trust Fund. Its Subcommittee on Health handles issues such as hospital and physician reimbursement under Medicare.

Rep. William (Bill) Thomas (R-CA)

Representative Thomas became chair of the Committee on Ways and Means in January, replacing retiring chair Bill Archer (R-TX). During the previous six years, he chaired the panel's Subcommittee on Health, and, in 1998, he served as the administrative chair of the National Bipartisan Commission on the Future of Medicare.

Representative Thomas is known for his active work on the Balanced Budget Act of 1997 (BBA), which, among other provisions, expanded health care delivery options for Medicare beneficiaries. To address some of the concerns expressed by physicians, hospitals, and other health care providers about the financial impact of the BBA, Representative Thomas authored the Balanced Budget Refinement Act of 1999 (BBRA) as well as the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Representative Thomas also introduced legislation in the 104th Congress that served as the basis of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Representative Thomas has been a member of the House of Representatives for 22 years. Before being elected to Congress, he served as a California State Assemblyman and as a professor of American government at Bakersfield College, Bakersfield, CA. For updated information on Representative Thomas' plans for health care in the 107th Congress, visit <http://tnd.house.gov>.

Rep. Charles Rangel (D-NY)

Representative Rangel was appointed the ranking minority member of the Committee on Ways and Means in 1997. As a senior member of that committee, Representative Rangel has continually fought against cuts in the Medicare program and in the federal welfare system. Faithful to his New York teaching hospital constituency, he also was very active in the 106th Congress on issues related to graduate medical education. Before his tenure in the House of Representatives, Representative Rangel served four years in the New York State Assembly.

Rep. Nancy Johnson (R-CT)

Representative Johnson is the newly appointed chair of the Ways and Means Health Subcommittee. As a long-time member of the subcommittee, Representative Johnson has been very active in health care reform issues. She played a major role in the construction of the BBA and its refinements, BBRA and BIPA, and is known for her steady



Rep. Bill Thomas



Rep. Charles Rangel



Rep. Nancy Johnson

fast support for extending Medicare coverage to cancer clinical trials. Representative Johnson founded the House Republican Task Force on Health Care in an effort to develop legislative proposals to control costs and ensure universal access to affordable care. Before being elected to Congress, Representative Johnson served as a member of the Connecticut State Senate.

Rep. Fortney H. (Pete) Stark (D-CA)

Representative Stark has served in the leadership of the Committee on Ways and Means since 1985, when he became chair of its Subcommittee on Health. In 1995, Representative Stark was named ranking minority member when the Republicans gained the majority in the House. During his tenure as chair, Representative Stark was one of the principal architects of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), which mandated the implementation of a Medicare physician fee schedule constructed according to a resource-based relative value scale. He also authored the Stark I and Stark II laws governing physician self-referrals.

Before Representative Stark was elected in 1972, he founded the Security National Bank in Walnut Creek, CA. He also served as Director of Common Cause, a citizen's lobbying group that works for reform in federal and state government.

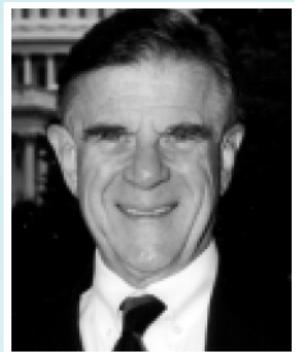
House Energy and Commerce Committee

The House Committee on Energy and Commerce has jurisdiction over health programs financed by general revenues (as opposed to trust funds), including Medicare part B and physician payment issues, Medicaid, and programs managed by the agencies of the Public Health Service, including the Food and Drug Administration, the Centers for Disease Control and Prevention, and the National Institutes of Health.

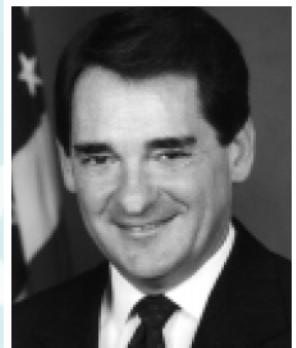
Known during the 104th to 106th Congresses simply as the House Commerce Committee, the committee's name was changed back this year to one held previously. Its jurisdiction also was changed somewhat, with much of its influence over insurance issues transferred to the newly renamed Committee on Financial Services. The committee's health issues are handled by its Subcommittee on Health (a newly renamed panel that no longer handles environmental issues).

Rep. Billy Tauzin (R-LA)

Representative Tauzin, known largely for his leadership on energy policy issues, was appointed the new chair of the House Committee on Energy and Commerce following the retirement of former Commerce Committee chair Tom Bliley (R-VA). A fiscal conservative, Representative Tauzin includes among his priorities as chair passage of a prescription drug benefit for seniors. He



Rep. Pete Stark



Rep. Billy Tauzin



Rep. John Dingell

Members of the House Health Subcommittees

Committee on Ways and Means Subcommittee on Health

Nancy Johnson (R-CT), <i>Chair</i>	Pete Stark (D-CA), <i>Ranking member</i>
Jim McCrery (R-LA)	Gerald Kleczka (D-WI)
Philip Crane (R-IL)	John Lewis (D-GA)
Sam Johnson (R-TX)	Jim McDermott (D-WA)
Dave Camp (R-MI)	Karen Thurman (D-FL)
Jim Ramstad (R-MN)	Philip English (R-PA)
Jennifer Dunn (R-WA)	

Committee on Energy and Commerce Subcommittee on Health

Michael Bilirakis (R-FL), <i>Chair</i>	Sherrod Brown (D-OH), <i>Ranking member</i>
Joe Barton (R-TX)	Henry Waxman (D-CA)
Fred Upton (R-MI)	Ted Strickland (D-OH)
James Greenwood (R-PA)	Tom Barrett (D-WI)
Nathan Deal (R-GA)	Lois Capps (D-CA)
Richard Burr (R-NC)	Ralph Hall (D-TX)
Ed Whitfield (R-KY)	Edolphus Towns (D-NY)
Greg Ganske, MD, FACS (R-IA)	Frank Pallone (D-NJ)
Charlie Norwood, DDS (R-GA)	Peter Deutsch (D-FL)
Barbara Cubin (R-WY)	Anna Eshoo (D-CA)
Heather Wilson (R-NM)	Bart Stupak (D-MI)
John Shadegg (R-AZ)	Elliot Engel (D-NY)
Charles Pickering (R-MS)	Albert Wynn (D-MD)
Ed Bryant (R-TN)	Gene Green (D-TX)
Robert Ehrlich (R-MD)	John Dingell (D-MI), <i>ex officio</i>
Steve Buyer (R-IN)	
Joseph Pitts (R-PA)	
Billy Tauzin (R-LA), <i>ex officio</i>	

Members of the Senate Health Care Committees

Health, Education, Labor and Pensions Committee

James Jeffords (R-VT), <i>Chair</i>	Edward Kennedy (D-MA), <i>Ranking member</i>
Judd Gregg (R-NH)	Christopher Dodd (D-CT)
Bill Frist, MD, FACS (R-TN)	Tom Harkin (D-IA)
Mike DeWine (R-OH)	Barbara Mikulski (D-MD)
Mike Enzi (R-WY)	Jeff Bingaman (D-NM)
Tim Hutchinson (R-AR)	Paul Wellstone (D-MN)
Susan Collins (R-ME)	Patty Murray (D-WA)
Sam Brownback (R-KS)	Jack Reed (D-RI)
Chuck Hagel (R-NE)	John Edwards (D-NC)
Jeff Sessions (R-AL)	Hillary Clinton (D-NY)

Finance Committee

Charles Grassley (R-IA), <i>Chair</i>	Max Baucus (D-MT), <i>Ranking member</i>
Orrin Hatch (R-UT)	John Rockefeller (D-WV)
Frank Murkowski (R-AK)	Tom Daschle (D-SD)
Don Nickels (R-OK)	John Breaux (D-LA)
Phil Gramm (R-TX)	Kent Conrad (D-ND)
Trent Lott (R-MS)	Bob Graham (D-FL)
James Jeffords (R-VT)	Jeff Bingaman (D-NM)
Fred Thompson (R-TN)	John Kerrey (D-MA)
Olympia Snowe (R-ME)	Robert Toricelli (D-NJ)
Jon Kyle (R-AZ)	Blanche Lincoln (D-AR)

voted for BIPA at the end of the 106th Congress to restore funding lost to Medicare from BBA and has served 12 terms in Congress.

Rep. John Dingell (D-MI)

Representative Dingell, a well-known health care advocate, is the most senior member of the House, having served since 1955. He was chair of the Committee on Energy and Commerce for 14 years before becoming the ranking minority member of the Commerce Committee in 1995. Representative Dingell, a strong supporter of the Medicare and Medicaid programs, was a member of the National Bipartisan Commission on the Future of Medicare.

In the 106th Congress, Representative Dingell and Rep. Charlie Norwood (R-GA) introduced the Patients' Bill of Rights, a comprehensive managed care reform proposal that passed the House with bipartisan support.

Before his tenure in the House, Representative Dingell was an assistant prosecutor.

Rep. Michael Bilirakis (R-FL)

Chair of the Subcommittee on Health (and its predecessor, the Subcommittee on Health and the Environment) since 1995, and representing a district predominantly composed of senior citizens, Representative Bilirakis has been at the forefront of drafting important health care legislation. His involvement in health care and his knowledge of the Medicare program led to his appointment to the National Bipartisan Commission on the Future of Medicare. His efforts on the Energy and Commerce Committee have led to the passage of key health care bills, such as HIPAA, the Ryan White CARE Act for the treatment and support of AIDS patients, and the Trauma Care Systems Planning and Development Act.

Representative Bilirakis, before being elected to Congress in 1982, worked as an attorney and as a county and municipal judge.

Rep. Sherrod Brown (D-OH)

Representative Brown, the ranking minority member on the Health Subcommittee, was elected in 1992 and immediately became involved in health care issues. He has authored and supported patient protection legislation for Medicare patients enrolled in managed care plans and is known for his active support of increasing federal support for cancer research, screening, and treatment.

Prior to his election to Congress, Representative Brown was a member of the Ohio State House. He also served as Ohio's Secretary of State.

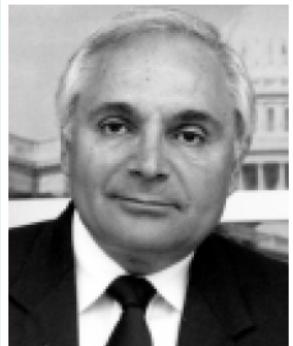
Senate Health, Education, Labor and Pensions Committee

The Senate Health, Education, Labor and Pensions Committee (HELP) has a health issue jurisdiction that is roughly equivalent to that of the House Energy and Commerce Committee. The panel is responsible for all federal health programs funded by the Public Health Service, although it has no authority over the Medicare and Medicaid programs. As is more common in the Senate, most of the HELP Committee's work is done by the full panel, with little responsibility delegated to its Subcommittee on Public Health and Safety.

Sen. James Jeffords (R-VT)

Senator Jeffords has chaired the HELP Committee since 1997. He is known for his relatively moderate stance on many health issues; in fact, he endorsed President Clinton's health care plan in 1993 and was a strong advocate for comprehensive managed care reform in the last Congress. As the HELP Committee Chair, Senator Jeffords says his highest priorities are children's health concerns, home health care, AIDS care and treatment, and the confidentiality of patient medical records. Before joining the Senate, Senator Jeffords served as a Vermont State Senator and in the U.S. House of Representatives.

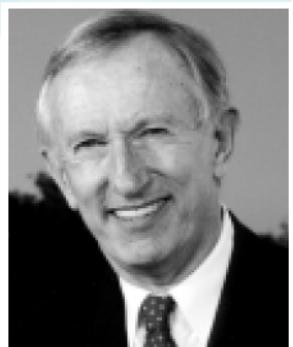
Sen. James Jeffords also serves as chair of the Senate Finance Subcommittee on Health Care (see page 21).



Rep. Michael Bilirakis



Rep. Sherrod Brown



Sen. James Jeffords

Sen. Edward Kennedy (D-MA)

Senator Kennedy has been active in health care reform for over 30 years. From 1987 to 1994, he chaired the HELP Committee's predecessor, the Senate Labor and Human Resources Committee. An advocate for sweeping health care reform, Senator Kennedy sometimes encounters difficulties in his efforts to enact legislation that he believes will benefit health care patients. Nonetheless, he was successful in securing the passage of HIPAA—also known as the Kennedy-Kassebaum bill. An attorney, Senator Kennedy was elected in 1962 to fill the unexpired seat of John F. Kennedy.

Sen. Bill Frist, MD, FACS (R-TN)

Thoracic and transplant surgeon Bill Frist, MD, FACS, elected in 1994, is the first practicing physician to hold office in the Senate since 1928. He was rewarded with a seat on the HELP Committee and immediately took an active role in health care policymaking. Senator Frist was a strong force in the passage of HIPAA, as well as legislation requiring health plans to allow at least 48-hour hospital stays for mothers and newborns. He also chaired the National Bipartisan Commission on the Future of Medicare.

As chair of the HELP Committee's Subcommittee on Public Health, Senator Frist has focused on medical savings accounts, reform of the Food and Drug Administration, the Ryan White CARE Act, organ donation, and trauma care system development.

Senate Finance Committee

The Senate Finance Committee may be viewed as the counterpart to the House Committee on Ways and Means. This panel handles revenue, trade, customs, and all health care programs that are authorized under the Social Security Act and financed by taxes and trust funds—including Medicare Part A and Medicare Part B. This committee handles Medicaid policy, as well. Again, most of the substantive work of the panel is done at the full committee level. Over the years, the Finance Committee has accrued more members from rural states, which could lead to an even greater focus on matters pertaining to rural health.

Sen. Charles Grassley (R-IA)

Senator Grassley is the newly appointed chair of the Senate Finance Committee, replacing the defeated Sen. William Roth (R-DE). Given that he spent three years as the chair of the Senate Aging Committee, Senator Grassley has been engaged in health care issues of concern to the elderly for quite some time. Senator Grassley is most known for his desire to bring health care equality to rural areas by providing federal support for the nation's small town hospitals and physicians. Prior to his election to the Senate, Senator Grassley was a working farmer in Iowa.



Sen. Edward Kennedy



Sen. Bill Frist



Sen. Charles Grassley

Sen. Max Baucus (D-MT)

In addition to a new chair, the Senate Finance Committee has a new ranking minority member, Senator Max Baucus. As a member of the Finance Committee, and now with a leadership role, Senator Baucus has always considered health issues among his main priorities. He has consistently supported legislation for cancer prevention and treatment, as well as BBA relief for rural hospitals and physicians.

Senator Baucus was elected to office in 1978 after practicing law and serving in the Montana State Legislature and the House of Representatives.

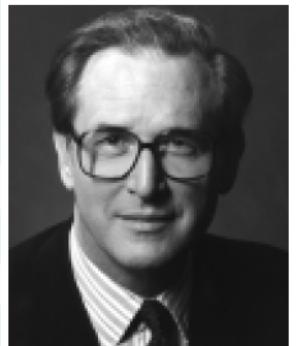
Sen. John D. Rockefeller IV (D-WV)

Sen. "Jay" Rockefeller, the ranking minority member of the Senate Finance Subcommittee on Health Care, has been a leader in health care delivery and financing issues for nearly 20 years. Senator Rockefeller was one of the principal architect's of OBRA '89 and the Medicare physician fee schedule. He was also a member of the National Bipartisan Commission on the Future of Medicare and one of its predecessor panels in the late 1980s, the Pepper Commission (the Bipartisan Commission on Comprehensive Health Care).

Senator Rockefeller moved to West Virginia in 1964 as a VISTA volunteer. Since then he has served as the state's Governor, as a member of the State House of Delegates, and as a U.S. senator since 1985. ☐



Sen. Max Baucus



Sen. Jay Rockefeller



Dealing with managed care organizations: A second opinion

by

**Lawrence A. Danto, MD, FACS,
Stockton, CA**

The question from the young surgeon was this: "I am new to practice and need some guidance on how to deal with managed care. What do you suggest?" (*Bulletin*, November 2000, p. 37). The well-intended and thoroughly constructed answer from the College broke the process down into 10 steps:

1. Perform background research on the managed care organization (MCOs).
2. Perform internal practice reviews of the MCOs.
3. Develop an MCO questionnaire.
4. Meet with MCO provider representatives.
5. Analyze the MCO's practice data.
6. Present to physicians for decision.
7. Negotiate the contract.
8. Renew or terminate contracts.
9. Educate the office staff.
10. Continue the process; repeat at least yearly.

These steps all seem worthwhile. However, upon reading them, even as an experienced surgeon, I was left with a strong feeling of frustration and hopelessness. Then it dawned on me; despite the fact that I have a fine surgical career in what I refer to as "the Garden of Eden of managed care" (the Sacramento and San Joaquin Valley), I have needed little of what the article recommended. So, why this disagreement?

Managed care's promise

I went to medical school and trained as a general surgeon at the University of Michigan and St. Joseph's in Ann Arbor, MI, during the 1960s. Even then, medical education, research, and practice were really about managed care—managing the care of a patient using protocols developed from studies showing which treatments provided the best outcomes. Medical education will always be about how to properly manage health care delivery—whether we call it "managed care" or not.

Clinical protocols were designed to provide an adjustable basic framework to support appropriate health care for a population of patients. If carried out too rigidly, patient care could no longer be adjusted according to an individual patient's needs. Such clinical rigidity was euphemistically referred to as "cookbook medicine." This kind of non-thinking practice has always been considered the dark side of managed care.

We were also taught to be our patients' advo-

cates and that if we concerned ourselves with what was in the best interests of our patients—even if it meant withholding unnecessary care and not receiving payment—in the end, they would do well and we would prosper. It has always been true that the most sophisticated and difficult health care decisions involve defining and withholding unnecessary care. Critical thinking of this nature is the essence of medical professionalism.

After a tour as a fleet surgeon in the Tonkin Gulf during the Vietnam War and two years on the full-time medical school faculty at the University of California-Davis, I went into the private practice of general surgery in Davis and Sacramento, CA, while maintaining my faculty appointment. In Sacramento, during the 1970s, the first non-Kaiser health maintenance organization (HMO) in the country was formed—Foundation Health Plan (FHP). I was in the inaugural group to participate in FHP. Other HMOs soon followed.

In the early 1980s, it became apparent that health care spending was still running away from the intended budget. The feeling was that physicians had failed, for various reasons, to control spending. Much of this was because the patient population was continually expanding and becoming more treatable because of advances in knowledge and technology. However, some of this inflation was also due to professional greed, often disguised in a self-righteous cloak of refusing to practice cookbook medicine.

We were the most highly trained professionals in history and not about to turn the practice of medicine into a non-thinking art. We also weren't about to give up the autonomy of fee-for-service billing. In the end, our good intentions were doomed because we failed to adhere to our mission of patient advocacy and to recognize the need for maintaining traditional professionalism.

Enter the gatekeepers

As a result of the medical profession's administrative disinterest and failure to reduce health care spending, nonphysician administrators took command of the MCOs. Health care spending, it was thought, must be brought under control through any measure. Because these new corporate heads and administrators were not physicians, it became easier to sacrifice medical professionalism and patient advocacy to the relative mindlessness of cook-

book health care. This, then, became the new standard of practice for marketplace MCOs—a cookbook.

The stage was set to try to control the health care budget by simply withholding or denying care. What had traditionally been the most critical decision in health care delivery now became easy, as the difference between necessary and unnecessary care no longer mattered to those granting access; they weren't health care professionals.

The economic device used by MCOs to control spending was called "capitation," and the crucial decision-making process used to control access was called "gatekeeping." Using capitation, MCOs pay contracting groups of physicians and hospitals a set amount over a given period of time to care for an individual, irrespective of how healthy (or unhealthy) that person may be, as if we were all the same. As long as health care needs fall within this cap, there is money to provide care. However, if a patient becomes too ill, the cost of care could exceed the cap and payment for care could end. The emphasis is on protecting financial reserves through the rigidly programmed authorization and denial of care. The obvious incentive for the capitated caregiver is to provide less care.

Gatekeeping is the decision-making process by which a capitated patient is authorized or denied health care. Gatekeepers are typically chosen for their inexperience with special health care decision making. Using out-of-specialty gatekeepers makes them easier to control by MCOs because they are unable to think critically about their decision-making process. Also, they are usually lower-income health care providers rewarded for their aggressiveness in denying care—the infamous "gatekeeping bonus" or "physician incentive."

Unfortunately, it is relatively easy for gatekeepers to deny care they don't understand, for patients they don't know, in a system that is already understaffed and overworked. Further, the appeals processes are usually too burdensome to be clinically meaningful. Further yet, even though the MCOs prebudget for certain legal losses, the Employee Retirement Income Security Act (ERISA) protects HMOs from most liability for their health care decisions.

From a business standpoint, the concept of capitated health care is brilliant. Corporate profit and administrative salaries are ensured because

they can be taken off the top of the health care dollar. In effect, the MCO is able to fund administrative salaries and stock dividends before any care is authorized. Overnight, the viability of a health insurance business became virtually a no-risk proposition. Health care spending quickly came under control because, when health care dollars ran out, spending stopped. When spending stopped, inflation stopped. Unfortunately, the number of patients without health care access continued to increase, as did the cost of care.

Medicine depersonalized

Another interesting change took place. We stopped hearing about patients and patient advocacy. These two important concepts were replaced with common industry terms, such as clients, customers, consumers, lives, and, the ultimate depersonalization, units. Instead of patient advocacy, we began hearing about consumer advocacy.

A consumer is a person who chooses to use common goods or services to maintain a desirable lifestyle. A patient is someone who must use special goods or services to maintain acceptable health—to maintain life. There is a big difference between the two, not just with respect to economics and market forces, but also with respect to issues of human rights and freedom of choice. A consumer may easily be regarded as a statistic, but a patient is always a person.

The results included the depersonalization of the most personal of human services, the crippling of a most honored vocation, and the destruction of our fundamental freedom of choice. Individuality was wiped away by a rigid economic protocol, by a cookbook. It all worked beautifully—for a while.

If disease, health, and life could be quantified, a cap could rightfully be placed on health care delivery, but such is not the case. Capitation is incapable of distinguishing patients from consumers. Capitation does not entitle patients to health care services; it entitles corporations to remain solvent. Using capitation, the managed care industry sacrifices access to health care for the sake of a balanced budget, and managed care has become nothing more than managed cost. The reality is that capitation is void of social purpose, and the only aspect of health care delivery that should be capitated is the cost of administration.

The HMOs, for obvious reasons, fear the loss of

capitation and gatekeeping, as well as the threats of re-personalization and the return of independence and choice to health care delivery. They continually link independent practice and fee-for-service with the runaway costs of health care delivery in the 1960s, '70s, and '80s. They use these fears (plus a fortune in lobbying funds) to control legislation. Worse, government lacks the will to stand against the health insurance industry and assume responsibility for assuring better access to care. It's all a thinly veiled form of insurance industry tyranny.

Managed cost replaces managed care

It is human nature to leave well enough alone. "Well enough" consists of a workforce that is largely healthy, needs little care, and (despite the recent economic slowdown) is living through one of our greatest periods of prosperity. The MCO industry tells us that the control of health care spending is "central" to this prosperity, and this may, in part, be true. Even so, we are sacrificing the health of a sizable segment of our population for the health of our economy by allowing the MCOs to capitate health care spending. We will be forced to deal with this reality by providing more expensive treatment in years to come for our patients who are denied care today.

MCO gurus counter by pointing to the emphasis they place on prevention. However, they are only concerned with preventive medicine for their own "clients," and then only if it doesn't cost too much, if it doesn't threaten their solvency. A booklet educating a patient on a low-salt or low-fat diet is one thing, but providing timely coronary bypass or hip replacement surgery is quite another. Further, the managed care industry completely ignores the historic commitment of the medical profession and the government to providing significant care, preventive or otherwise, for the underfunded populations. The MCOs are, in effect, cost-shifting their expenses into our children's economic future.

HMOs ignore that our standards of quality were established by physicians unconfined by capitation and gatekeeping and are maintained by specialists whose residual professionalism drives them to do their utmost for patients regardless of how the MCOs cut payments. Physician professionalism, like a fatal flaw, helps keep the MCOs solvent. Even so, last year saw the return of double-digit infla-

tion in health care costs.

While they are eager to use the research, clinical protocols, and health care providers that come out of our universities and government institutions, the MCOs spend little of their resources funding the process. The MCOs pay only a small fraction of the billions of dollars spent on medical education, research, and development. Most health care "R&D" money comes from tax dollars and the manufacturing industry that will profit from the sale of its products to the MCOs.

Here is the strange scenario: The MCO patients work, earn livings, and pay taxes. Billions of dollars of this tax money goes toward government-sponsored medical education and research. The MCOs base their operations on the knowledge acquired, basically free of charge, from this process and then profit from the denial of health care to the very patients who paid the taxes to begin with. This bizarre relationship is a vital part of the parasitic MCO life cycle.

The remnants of managed care

The reality of health care delivery in a humane industrialized society is that the patient population continually gets larger, older, and more treatable. Therefore, the cost of health care delivery must increase as time passes. The only way to live with this situation is to define the basics of health care in a responsible fashion, minimize inflation, and commit to a solvent delivery system that is financially able to sustain the provision of basic care.

To this end, quality health care, universal access, patient individuality, independent practice, professionalism, and even fee-for-service in health care delivery are completely compatible with managed care and MCOs. However, the health care delivery system should not be employer- or employee-based because such a system eliminates the hope for universal access by barring access to the unemployed. It cannot be capitated because the MCOs have shown us that capitation just guarantees corporate solvency while destroying the individuality, choice, and professionalism inherent in proper health care delivery. Finally, gatekeeping should be kept within specialties; to do otherwise is morally and intellectually dishonest. Gatekeeping out of specialty devalues patient advocacy, medical professionalism, and patients' rights.

The cost of health care continues to climb and insurance premiums continue to increase. Large commercial independent practice associations are going bankrupt. Other MCOs—after a series of mergers, realignments, and lawsuits—are failing. This includes a large number of badly needed metropolitan and rural hospitals. Some MCOs are beginning to reject capitated contracts in an attempt to return to the open market. Our health care safety net has been left threadbare.

The number of uninsured Americans under age 65 who are without financial access to regular medical care continues to climb. There is a surging feeling that if MCOs don't reinvent themselves they will soon perish, and it is highly unlikely they will reinvent themselves because there's no longer enough money in it. The result of all this is that the U.S. is experiencing one of the greatest socio-economic transformations in its history—possibly the greatest since the abolition of slavery and the industrial revolution. How can any young surgeon go through an intelligent, cost-effective process of negotiation, even on a small scale, with a system that is failing this way?

The legendary English physician and teacher, Sir William Osler, wrote that there were three "A's" to successful medical practice, and he listed them in decreasing order of importance: availability, affordability, and ability. However, industrialized managed care is purposefully designed and administered to systematically restrict availability. Recent history tells us there is certainly little affordability left in the MCO system. Sadly, in the end, all the ability in the world is useless to a patient who can't struggle through the gates. As stated earlier, the reality is that marketized health care delivery has no social purpose and provides Americans with much less care than is theirs by right. How can any of us seriously negotiate with such a system?

Having said all this, I love the original promise of managed care—that it would be the door to the future of quality health care delivery. However, I have grown to hate the MCOs.

The second opinion

Finally, let's get back to the original question: "I am new to practice and need some guidance on how to deal with managed care. What do you suggest?" After reviewing all the contradictions and fallacies associated with MCOs, my best advice is to worry

less about negotiating with the corporations and focus more on truly managing care. Hence, here is my simple, effective plan for dealing with MCOs:

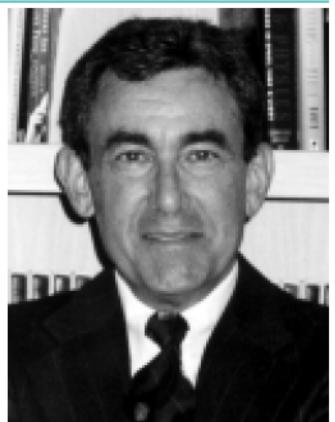
1. Get the best training available.
2. Stay well educated.
3. Become a strong advocate for your patients.
4. Put yourself in a position to care for the largest patient population it interests you to serve, but care only for those you can help and help triage the rest.
5. Don't worry about dealing with the MCOs; let them worry about dealing with you.

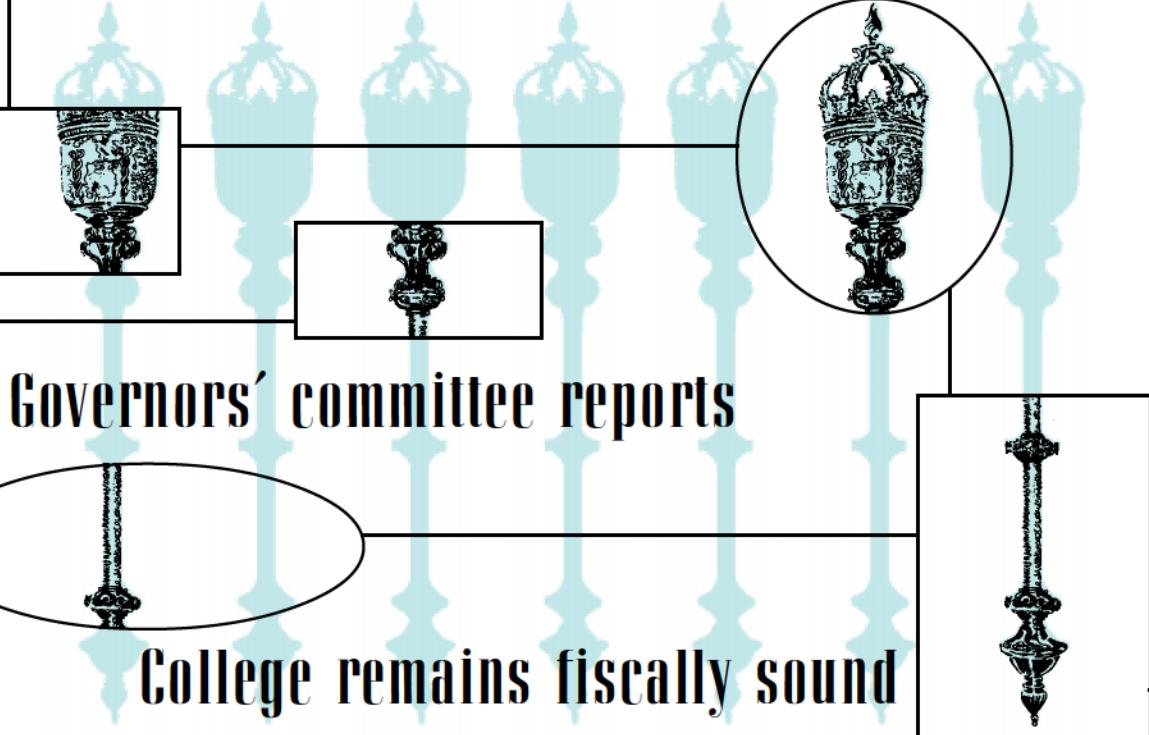
6. "This above all, to thine own self be true:
And it must follow as the night does the day,
Thou canst not then be false to any man."

(William Shakespeare—*Hamlet*)

As physicians and surgeons we must stay true to ourselves as well as to our profession. No one else can provide the care we provide—and the MCOs are worried.

Dr. Danto, a general surgeon, is vice-chairman of surgery, San Joaquin General Hospital, Stockton, CA, and clinical professor of surgery, University of California, Davis.





by William F. Sasser, MD, FACS, St. Louis, MO

Editor's note: This is the second in a series of articles by the chairs of the individual Board of Governors' (B/G) committees. The articles are intended to highlight the work of the committees, so that Fellows will seek out the committee chairs if they are interested in specific issues. This article focuses on the B/G Committee to Study the Fiscal Affairs of the College.

For the eight months ending August 31, 2000, the College's financial results were favorable compared with the budget. The positive outcome is the result of unfilled staff positions, cost savings, and decreases in cancer surveys and practice management seminars. The year-end results also were favorable. While the budget for 2000 contained a modest surplus, current projections for year-end 2000 show an excess of revenues over expenses of more than \$3 million.

Assets

The College's assets, which include operating assets, real estate, and investments, totaled \$272 million as of August 31, 2000. The net investment activity of \$2 million for the first eight months of the year provides substantial support for College activities. The market value of the pooled fund investments was \$208 million.

The Investment Subcommittee of the Regents' Finance Committee was initiated in June 1999 and since then has completed a review of all of the College investment managers. Based on the managers' performance review, the subcommittee recommended the appointment of a new value-added manager and diversification of the portfolio into oil and gas and real estate markets (5% allocation each). The diversification will help moderate fluctuations in any asset class. The new appointments were approved by the Finance Committee and the Board of Regents.

The net investment returns for the quarter end-

ing September 30, 2000, were 1.9 percent, compared with the consumer price index of 0.8 percent and the Cambridge Endowment Median of 1.2 percent. The diversification of the portfolio into real estate and oil and gas produced net returns for the quarter of 7.7 percent (33.1% return for year-to-date performance). The Investment Subcommittee will present for the Regents' approval the statement of investment objectives and policies and investment roles and responsibilities.

Other financial matters

The Board of Regents appointed Deloitte and Touche, LLP, to serve as the independent auditor for the College effective for 2000. The fiscal year end for the College will change to June 30. The change will provide more accurate information for preparation of the annual budget. The College will have a six-month end June 30, 2001, and start the next fiscal year July 1, 2001.

The Board of Regents approved changes to the *Bylaws* to update insurance requirements for officer positions and to define the authority and authorization levels between the Board of Regents, the Executive Director, and the Comptroller.

Pension plan

The committee reviewed the annual report of the staff members' retirement plan. This defined benefit plan had assets of \$10.4 million and benefit obligations of \$9.8 million on December 31, 1999. An actuarial valuation of the plan is performed by actuaries at William M. Mercer, Inc., and the plan is audited by the College's public accounting firm, KPMG Peat Marwick. A contribution to the plan of \$816,310 is necessary for the year 2000. The plan's assets are supervised by the Investment Subcommittee. At the last meeting of the Investment Subcommittee, the asset allocation policy was reviewed. The retirement plan's liabilities are finite and nondiscretionary. In addition, retirement payments when required may cause the organization to liquidate equities at low prices. Advisors and the Investment Subcommittee agreed that an asset allocation of 60 percent equities and 40 percent bonds was appropriate for the retirement plan assets.

The long-term savings plan for College staff is a 403(b) tax-deferred annuity plan. Participation is voluntary. After one year of service, an individual's

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contribution is matched at the rate of 50 percent up to a maximum College match of 3 percent of salary.

Insurance program

The ACS Insurance Trust offers term life, health, long-term disability, office overhead expense, and accidental death and dismemberment coverage for Fellows, Associate Fellows, and members of the Candidate Group. At the end of the last policy year, there were 6,926 surgeons insured by the program, which covers 13,961 policies. The program generated annual premiums of \$24.1 million and is financially sound, with a cost stability reserve of \$13 million.

As the program enters its 51st year of providing high-quality benefits to surgeons and their families, the College is exploring new alternatives to increase the product offering. Activities over the past year include: an offer of 10 percent additional term life insurance benefit at no cost; no-cost term life, accidental death and dismemberment, and long-term disability insurance for new members; a super-preferred plan for underwriting classification and premium rates for life insurance; and a new product offering of small group major medical insurance. Four other products are under evaluation, including Medicare supplement, critical illness, short-term major medical, and hospital indemnity. The health and disability coverages have experienced the same premium pressures as other plans. Premium increases and benefit changes are based on the actual plan claim experience.

Development Program

Philanthropic contributions to the College totaled \$898,794 as of September 20, 2000. Twenty-one new life members (pledges of \$10,000 or more) have been recorded. There are now 285 members of the Fellows Leadership Society who are have attained Life Member status or higher. Twenty state chapters and eight specialty societies also contribute to the Development Program.

The 12th annual Fellows Leadership Society Awards luncheon was held October 23, 2000, at the Chicago Hilton and Towers. The committee's nomination for Distinguished Philanthropist elected to remain anonymous and, as a result, the Distinguished Philanthropist Award was not presented for the year 2000.

Fred Holzrichter, CFRE, Manager of the ACS Development Program, and Robert Berry, MD, FACS, Chair of the Committee on Development, have been very busy this past year. The committee developed its purpose and vision statements in addition to receiving the Board of Regents' approval for an initial listing of "Named Gift Opportunities."

Scholarships, fellowships, and other awards

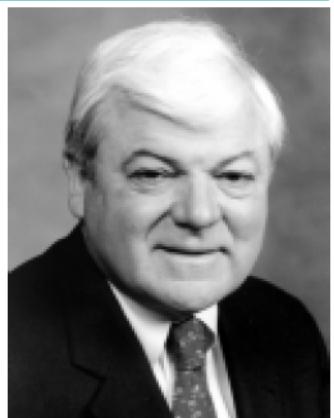
The Board of Regents approved funding of \$1.46 million for resident research scholarships, faculty fellowships, six international guest scholarships, and the 11th Clowes Research Career Development Award to commence in the year 2002. The Board also approved a jointly sponsored Faculty Career Development award for Oncology of the Head and Neck. The awards are funded through the 2000 annual fund, from the various endowment funds available for scholarships and fellowships, as well as from a \$6,000 grant from Ethicon, Inc.

Dues and fees

As of August 31, 2000, the percentage of dues collected was about equal to the 1999 and 1998 collections of the same date. After discussion of the College's financial position and projections for the short six-month 2001 budget, the committee recommended no increase in dues. This will be the ninth consecutive year without a significant dues increase. The general endowment fund investments significantly mitigate the need for increased dues. Approximately 37,000 Fellows pay dues totaling \$13.68 million. The remainder have reached

continued on page 49

Dr. Sasser is chief division of thoracic surgery, St. John's Mercy Medical Center, St. Louis, MO, and Chair of the B/C Committee to Study the Fiscal Affairs of the College.



Ten specialty boards report accomplishments and plans: Part II

Each year, the 10 surgical specialties recognized by the American Board of Medical Specialties report to the ACS Board of Regents. Their reports are published in a condensed form in the *Bulletin* to keep Fellows abreast of any changes in the procedures of the various boards. The American College of Surgeons makes nominations to the following six boards: The American Board of Colon and Rectal Surgery, the American Board of Neurological Surgery, the American Board of Plastic Surgery, the American Board of Surgery, the American Board of Thoracic Surgery, and the American Board of Urology.

This issue of the *Bulletin* contains the reports of the American Board of Otolaryngology, the American Board of Plastic Surgery, the American Board of Surgery, the American Board of Thoracic Surgery, and the American Board of Urology. The reports of the American Board of Colon and Rectal Surgery, the American Board of Neurological Surgery, the American Board of Obstetrics and Gynecology, the American Board of Ophthalmology, and the American Board of Orthopaedic Surgery appeared in the March 2001 issue of the *Bulletin*.

American Board of Otolaryngology

by Gerald B. Healy, MD, FACS, Boston, MA

The American Board of Otolaryngology (ABOto) is pleased to report the following.

Qualifying/certifying examinations

The American Board of Otolaryngology continues to administer a two-part examination. Candidates must first pass a written qualifying exam and then pass an oral examination in order to become certified.

The written examination was administered to 334 candidates in October 1999 in five locations: New York, Chicago, Atlanta, Houston, and San Francisco. Of the 334 individuals, 307 became candidates for the oral examination. The oral examination was conducted by approximately 120 individuals, including ABOto directors, senior examiners, and guest examiners April 9-10, 2000, in Chicago. A total of 346 candidates were examined; 321 passed the exam and became certified.

Otolaryngology training exam

The otolaryngology training exam (previously the annual otolaryngology exam) was conducted March 4, 2000, in more than 100 locations, including several overseas. This is the third year the exam has been prepared and conducted by the ABOto. More than 1,200 residents and practitioners participated in the exam.

Elections

Michael E. Johns, MD, FACS, was elected to a two-year term as president of the ABOto. David E. Schuller, MD, FACS, was elected to serve a two-year term as president-elect. Gerald B. Healy, MD, FACS, a College Regent, was re-elected to a second term as executive vice-president. H. Bryan Neel III, MD, FACS, continues his term of service as treasurer.

After many years of dedicated service to the ABOto, Jerome C. Goldstein, MD, FACS, Alexander J. Schleuning, MD, and Neil O. Ward, MD, FACS, were elevated to senior counselors at the conclusion of the 2000 annual meeting in April.

Meanwhile, Richard A. Chole, MD, Jack L. Gluckman, MD, FACS, and Jesus E. Medina, MD, FACS, were elected to the board of directors. Dr. Chole is Lindburg Professor and head of the department of otolaryngology-head and neck surgery at Washington University in St. Louis, MO. Dr. Gluckman is professor and chair of the department of otolaryngology-head and neck surgery at the University of Cincinnati Medical Center in Cincinnati, OH. Dr. Medina is the Paul and Ruth Jonas Professor in Cancer Research and chair of the department of otorhinolaryngology at the University of Oklahoma Health Sciences Center in Oklahoma City, OK. All served as guest examiners and senior examiners prior to their election as directors.

Senior examiners

The ABOto is committed to electing and training new examiners while maintaining consistency in administering the examination. To accomplish this goal, the position of senior examiner was established a number of years ago. Senior examiners serve as the core group of experienced examiners, along with ABOto directors. Senior examiners are elected to five-year terms, and are eligible for re-election to one additional term after a hiatus of three years. To be elected a senior examiner, an individual must have served as an ABOto examiner at least twice. He or she must be prominent in the specialty, especially in the areas of patient care and medical education, and must demonstrate an interest and ability in the creation of educational and test materials.

After the 2000 annual meeting, the following surgeons completed their terms as senior examiners: Robert A. Dobie, MD, FACS; Paul J. Donald, MD, FACS; Ellen M. Friedman, MD, FACS; Herman A. Jenkins, MD, FACS; Douglas E. Mattox, MD, FACS; Michael D. Maves, MD, FACS; William J. Richtsmeier, MD, FACS; Clarence T. Sasaki, MD, FACS; Nancy L. Snyderman, MD, FACS; and Ernest A.

Weymuller, Jr., MD, FACS. Their successors are: Thomas J. Balkany, MD, FACS; Charles W. Beatty, MD, FACS; Brian B. Burkey, MD, FACS; Amelia F. Drake, MD, FACS; David W. Eisele, MD, FACS; David W. Kennedy, MD, FACS; John F. Kveton, MD, FACS; Robert M. Naclerio, MD, FACS; Stephen S. Park, MD, FACS; Myles L. Pensak, MD, FACS; Tom D. Wang, MD, FACS; Mark C. Weissler, MD, FACS; D. Bradley Welling, MD, FACS; and Gregory T. Wolf, MD, FACS.

American Board of Medical Specialties

The American Board of Medical Specialties (ABMS) is the umbrella organization of the 24 recognized certifying organizations in the U.S. Representatives to the ABMS assembly in 2000

were Drs. Healy, Johns, and Goldstein. Alternate representatives were A. Julianna Gulya, MD, FACS; Robert H. Ossoff, MD, FACS; and Robert H. Miller, MD, FACS. Charles J. Krause, MD, FACS, served on the ABMS task force on competence and represented the Council of Medical Specialty Societies to the ABMS assembly.

2000-2001 examination dates

The written examination was conducted on Monday, September 18, 2000, in Chicago, IL, Boston, MA, Houston, TX, San Francisco, CA, and Charlotte, NC. The subsequent oral examination is scheduled to be conducted in Chicago on April 20-21, 2001. The next OTE will be on Saturday, March 3, 2001.

American Board of Plastic Surgery

by William B. Riley, Jr., MD, FACS, Sugar Land, TX

The American Board of Plastic Surgery (ABPS) is pleased to report the following.

Examinations

The March oral examination statistics were reported in 1999. In September 1999, 203 candidates took the oral examination; 170 candidates passed and 33 failed, making the failure rate 16.3 percent. This failure rate was 1 percent lower than the previous year but compatible with the range of 17 percent to 25 percent for the last four years. An additional 393 diplomates were certified in two examinations given in March and September 1999. To date, the ABPS has certified 5,898 plastic surgeons. A total of 287 candidates registered for the oral examination on September 7-9, 2000. The double oral examination in 1999 reflected the transition of the changes made to the examination structure.

The written, or qualifying, examination was held September 6, 2000, for approximately 270 candidates. Results of the 2000 written examination were distributed in November 2000. In 1999, 221 candidates passed the written exami-

nation with a failure rate of 16.6 percent, which was consistent with prior years.

The board will initiate a new cognitive core surgery examination (CSE) in 2003 to be given during prerequisite training. The purpose of the CSE is to ensure a uniform core of knowledge of surgery as it pertains to plastic surgery obtained from all the prerequisite pathways. Residents entering training in an appropriate surgical discipline on or after July 1, 2001, are required to successfully complete the CSE before applying for the written examination, which is the first step in the examination and certification process of the ABPS.

Subspecialty certification

The 1999 certificate of added qualifications in surgery of the hand (CAQSH) examination was administered to 48 ABPS diplomates, 26 of whom were recertifying. Of the 22 taking the CAQSH examination, 21 passed, indicating that the failure rate was 4.5 percent. For the 1999 CAQSH recertification examination, of the 26 diplomates sitting for the examination, 23 passed; the failure rate was 11.5 percent. The 2000 certification examina-

tion in surgery of the hand was administered on August 28, 2000, to 64 candidates, 25 of whom are recertifying. Results were announced in mid-October.

Recertification

The first recertification examination will be offered in 2003. The first time-dated certificates will expire in 2005. The cognitive examination will be offered as a computer-based test (CBT) format in four modules: comprehensive plastic surgery; cosmetic/breast surgery; craniomaxillofacial surgery; and hand surgery. A subspecialty certificate in surgery of the hand will be accepted in lieu of the hand surgery module cognitive examination component of the maintenance of certification process. A number of changes, reflecting the recommendations of the American Board of Medical Specialties' (ABMS) Task Force on Competence, have been made in the structure of maintenance of certification process.

Changes in examination structure

Approximately 33 percent of the new diplomates certified in September 1999 were residents from the 1998 class who achieved certification in 14 months as a result of the board's restructuring of the examination process. The oral examination now consists of one case report session and two theory and practice sessions. Case list compilation covers a seven-month period, which begins in July after completion of residency training, and the board selects five cases for examination.

American Board of Medical Specialties

The ABPS and the American Board of Otolaryngology are continuing to discuss implementation of the subcertification of plastic surgery "within the head and neck." ABMS approved the ABPS application for plastic surgery within the head and neck at the Committee on Certification, Subcertification, and Recertification meeting on September 22, 1999. Both boards have agreed to now focus on the accreditation process through the Accreditation Council for Graduate Medical Education.

Subspecialty issues

The ABPS is committed to the engagement, development, and recognition of subspecialty in-

terests for the purpose of advancing the core of the entire specialty. Board members met in November 1999 with subspecialty leaders and the residency review committee to continue discussion of issues. The board has added four advisory councils to the board as of May 2000. The advisory councils reflect the four identified subspecialty modules for the maintenance of certification process, and the members include board directors and nominees from plastic surgery subspecialty organizations.

Competence

A special board retreat on competence is scheduled for November 2000.

Officers and directors

The ABPS honored the following directors at the May board meeting: David J. Smith, Jr., MD, FACS, 1993-2000; Elof Eriksson, MD, FACS, 1994-2000; and Henry K. Kawamoto, Jr., MD, FACS, 1994-2000.

The new directors elected to the ABPS are: Ronald E. Iverson, MD, FACS; Randolph Sherman, MD, FACS; and Thomas R. Stevenson, MD, FACS.

ABPS officers for 2000-2001 are: William B. Riley, Jr., MD, FACS, chair; John Bostwick III, MD, FACS, chair-elect; John J. Coleman III, MD, FACS, vice-chair; and David L. Larson, MD, FACS.

American Board of Surgery

by Frank R. Lewis, Jr., MD, FACS, Detroit, MI

During the 1999-2000 academic year the American Board of Surgery (ABS) held a retreat on "competence," witnessed the continued maturation of the sub-board/advisory council concept, and made a number of other decisions that may be of interest to College Fellows.

Retreat on competence

In January 2000, the directors held a retreat to consider the present status and future initiatives of its competence program—an effort to develop closer links between maintenance of certification, particularly at the time of recertification, and competent performance in practice. Six experts in the field addressed the issue: David L. Nahrwold, MD, FACS, chair of the American Board of Medical Specialties' (ABMS) task force on competence; David C. Leach, MD, executive director of the Accreditation Council for Graduate Medical Education (ACGME); Woodrow A. Myers, Jr., MD, director of health care management for Ford Motor Company; C. James Carrico, MD, FACS, Chair of the College's Board of Regents; Shukri F. Khuri, MD, FACS, chief of surgery at the Brockton/West Roxbury Veteran Affairs Medical Center; and William C. Nugent, MD, FACS, professor of surgery at Dartmouth-Hitchcock Medical Center.

At the conclusion of the retreat, the directors agreed to endorse the concept of requiring that maintenance of certification include continued evidence of: high standings within the profession, commitment to lifelong practice-based learning and practice improvement, a satisfactory cognitive knowledge base, and adherence to high standards of patient care throughout one's professional life. The directors also endorsed the concept of collaborating with the College and select surgical societies in the areas of practice-based learning and practice assessment.

The directors also agreed to explore methods of voluntary outcomes assessment for all diplo-

mates in an effort to stimulate improvement in patient care.

Pediatric surgery sub-board

At the January 1998 board meeting, the directors undertook a major reorganization of the structure of the board by developing sub-boards and advisory councils. This endeavor is part of a good-faith effort to recognize and promote the legitimate aspirations of mature and emerging surgical specialties and to strike an appropriate balance between disciplinary independence, initiative and growth, and the inimical consequences of separation from the basic discipline.

At the June 2000 board meeting, the directors unanimously approved the creation of a new sub-board in pediatric surgery. Members of the sub-board will include the pediatric surgical directors of the ABS and representatives from the American Pediatric Surgical Association, the Surgical Section of the American Academy of Pediatrics, and the ACS Advisory Council for Pediatric Surgery.

New CME requirements

The directors of the ABS have approved new continuing medical education (CME) requirements for recertification in vascular surgery, pediatric surgery, and surgical critical care. Beginning in 2002, diplomates must present evidence that they have accumulated 100 hours of CME relevant to the maintenance of qualifications in those disciplines during the two years prior to submitting an application for recertification. At least 60 of these hours must meet the criteria for Category I activities.

The ACS Surgical Education and Self-Assessment Program (SESAP) is included in Category I activities and will be credited at 60 hours. All Category I activities must be listed on the application forms and must be accompanied by the appropriate documentation. The remaining 40 hours of education may be in Category II activi-

**American Board of Surgery
Summary of 1999-2000 examinations**

	# of examinees	Pass rate	# of diplomates to date
Qualifying	1,323	78%	—
Certifying	1,287	80	45,176
Recertification	1,619	93	11,634
Vascular surgery qualifying	114	80	—
Vascular surgery certifying	109	97	1,985
Vascular surgery recertification	124	95	960
Surgical critical care	82	90	1,782
Surgical critical care recertification	126	86	428
Pediatric surgery qualifying	58	91	—
Pediatric surgery certifying	84	93	817
Pediatric surgery recertification	57	93	463
Hand surgery	4	25	214
Hand surgery recertification	13	77	42
Pediatric surgery in-training	70	N/A	—
In-training/surgical basic science	<u>7,276</u>	N/A	—
Total	<u>12,346*</u>		

N/A—not applicable.

*5,000 examinees, excluding the IT/SBSE and pediatric surgery ITE.

ties, which include less structured learning educational experiences.

New policy regarding certificate revocation

At the January 2000 board meeting, the directors approved a new policy regarding certificate revocation. The essence of the policy is that the directors may consider sanctions, including certificate revocation, if a diplomate:

- Was not qualified to receive the certificate initially.
- Misrepresents his/her status with regard to certification.
- Engages in conduct resulting in revocation, qualification, or other limitation of licensure.
- Engages in conduct resulting in expulsion, suspension, or other limitation from membership in an organization of professional peers.
- Engages in conduct resulting in revocation,

suspension or other limitation of privileges to practice surgery.

An appeals process also has been put into place. For details, diplomates may contact the ABS Web site at www.absurgery.org.

Exam irregularities

The board has begun to use a sophisticated statistical program to detect examination irregularities on the in-training surgical basic science examination (IT/SBSE). The program compares each examinee's answers with those of the other 7,000 examinees to determine the incidence of answer sheet concordance and the probability that the concordance occurred by chance (the threshold: a probability of less than one in a million).

Sadly, analysis of the 2000 IT/SBSE uncovered a number of matches in several programs. While the root causes of this type of conduct are of

great concern and need to be explored thoroughly, the validity of the examination mandates that prompt action be taken. All program directors have been alerted to the absolute necessity of increased attention to examination security during its administration and have been informed that repeated lapses in future years may result in programmatic exclusion from examinations.

In addition, candidates have been informed that the ABS knows the identities of the individuals involved and will not tolerate such behavior when future board examinations are given. As a postscript, the directors found it difficult to imagine a more distressing situation for a discipline that prides itself on setting and maintaining high moral and ethical standards.

Vascular surgery sub-board

The vascular surgery sub-board (VSSB) continued to involve itself deeply in examination issues, residency review committee concerns, and a variety of other matters. For instance, the sub-board reviewed the results of the 1999 vascular surgery qualifying examination and reaffirmed the appropriateness of using the equating method to determine the final cutting score. It also noted that 10 percent of the vascular surgery training programs were responsible for almost 60 percent of the failed candidates and agreed to share that information generically with the Association of Program Directors in Vascular Surgery. A completely revamped, revitalized vascular surgery certifying examination was given in May 2000, thanks in large part to the efforts of Dennis F. Bandyk, MD, FACS, James O. Menzoian, MD, FACS, and Kimberley J. Hansen, MD, FACS. All of the clinical scenarios were, for the first time, accompanied by illustrative material and at least half of them were new and complex. The overall failure rate was a low 2.8 percent, reflecting the extremely high caliber of the candidates.

At the behest of the Association of Program Directors in Vascular Surgery, the VSSB asked the residency review committee (RRC) to clarify the recent statement published in its newsletter in which a balanced experience in vascular surgery was expected in the training of general surgery residents in vascular surgery procedures. It also requested that the RRC monitor the experience of the finishing vascular surgery fellows in traditional

vascular surgical procedures so that appropriate adjustments could be made in the requirements if that experience showed substantive decreases over time.

The VSSB also collaborated with the RRC to produce identical surgical operative logs required of vascular surgery trainees by both the ABS and the RRC. In addition, it urged the RRC to consider accrediting two-year vascular surgery fellowships in order to provide trainees with an expanded clinical experience in endovascular vascular surgery. The RRC agreed to do so on a case-by-case basis.

A more complete listing of the activities of the VSSB can be found in an article entitled "The Vascular surgery sub-board: Progress report" (*Journal of Vascular Surgery* 2000; 31:1060-1065).

Surgical oncology advisory council

During the last year, the surgical oncology advisory council (SOAC) continued to review surgical oncology items on all ABS written examinations for clarity, correctness, and relevance to the practice of surgery. The clinical scenarios on the certifying examination were reviewed in January 2000, and the oncology items on the recertification examination were reviewed in June 2000, thus completing the process.

The relationship of the SOAC and the Society of Surgical Oncology (SSO) to the competence initiative was also extensively discussed. It was decided that the SOAC could be of help in several areas: developing a potential oncologic module for the proposed mandatory and proctored assessment of cognitive knowledge, piloting of such a module once developed, arriving at a core body of knowledge in surgical oncology deemed critical to the competent performance of all general surgeons involved in oncologic surgery, assessing outcomes in oncologic disease, and developing a method of defining and measuring improvement in practice. It was agreed that the SOAC should act as the leadership group in this effort and that at the next meeting of the SSO, the SOAC should outline the importance of the competence initiative to individual members of the SSO. It also was agreed that the SOAC should urge the SSO to create a committee to work with the SOAC to generate risk-adjusted measurement instruments.

In other matters, the SOAC was informed that the SSO's in-training examination was not being

pursued at present because of an inability to demonstrate that it either imparted knowledge or improved performance. Instead, the SSO's training committee has committed itself to creating a critical bibliography for fellows (available on the SSO Web site) and to refining the teaching of a defined curriculum. The SOAC also discussed the current status of SSO-endorsed breast fellowships. The discussion emphasized that there was greater interest in defining an appropriate educational curriculum than in creating an accreditation methodology. In any case, the SOAC unanimously rejected the idea of creating a certificate in this area. In other business, the SOAC was most helpful to the ABS in commenting on the oncologic aspects of a proposal from the residency review committee for dermatology to create fellowships in "surgical dermatology." The outcome of that initiative is yet to be determined.

New and retiring directors

The board would like to express its gratitude for the faithful services and exceptionally wise counsel of the following directors who have retired: Glenn D. Steele, Jr., MD, FACS, chair; Lawrence Y. Cheung, MD, FACS; Daniel L. Diamond, MD, FACS; Anthony A. Meyer, MD, FACS; Richard A. Prinz, MD, FACS; and Ronald G. Tompkins, MD, FACS. The board is also most appreciative of the fine efforts of Courtney M. Townsend, Jr., MD,

FACS, and Anthony D. Whittemore, MD, FACS, who served, respectively, as members of the surgical oncology advisory council and the vascular surgery sub-board.

The board also extends a welcome to new directors elected in April: William G. Cioffi, Jr., MD, FACS, from the American Association for the Surgery of Trauma; Timothy C. Flynn, MD, FACS, from the Association of Program Directors in Surgery; Keith E. Georgeson, MD, FACS, from the Association of Pediatric Surgery Training Program Directors; James C. Hebert, MD, FACS, from the New England Surgical Society; Keith D. Lillemoe, MD, FACS, from the American College of Surgeons; Michael S. Nussbaum, MD, FACS, from the Central Surgical Association; and Courtney M. Townsend, Jr., MD, FACS, from the American Surgical Association.

The board also welcomes Peter W.T. Pisters, MD, FACS, to SOAC and Bruce J. Brener, MD, FACS, to VSSB.

Necrology

It is with great regret that the board must report the deaths of the following senior members: Joel W. Baker, MD, FACS (July 4, 1999); Eugene M. Bricker, MD, FACS (January 1, 2000); Nicholas A. Halasz, MD, FACS (July 16, 1999); Keith Reemtsma, MD, FACS (June 23, 2000); and John A. Schilling, MD, FACS (November 29, 1999).

American Board of Thoracic Surgery

by Fred A. Crawford, Jr., MD, FACS, Charleston, SC

The American Board of the Thoracic Surgery (ABTS) is pleased to provide the following report.

Recertification changes effective 2001

In 1976, the ABTS first issued time-limited certificates. Ten years later, the certificates expired and the annual recertification process began. The requirements for recertification remained unchanged for 22 years. The directors of the board recently reviewed these requirements in light of

the many changes in the health care industry and the credentialing requirements of hospitals and third-party payors. The board also compared its recertification policies with those of other American Board of Medical Specialties (ABMS) members. Changes in the ABTS recertification resulting from this review policy will be implemented in 2001.

A valid ABTS certificate is an absolute requirement for entering the recertification process in 2001 and beyond. Beginning in 2001, the only

pathway for renewing an invalid certificate will be to take and pass the part I (written) and the part II (oral) certifying examinations. Effective in 2001, the continuing medical education (CME) requirement is 70 Category I credits in either cardiothoracic surgery or general surgery earned during the two years prior to applying for recertification. Not all Category I credits will be allowed; for instance, Self-Education Self-Assessment in Thoracic Surgery (SESATS) and the Surgical Education and Self-Assessment Program (SESAP) are the only self-instructional material acceptable for CME credit. The physicians' recognition award for recertifying in general surgery will not be accepted in fulfillment of the CME requirement. Other specific CME requirements will be published in the recertification *Booklet of Information*.

Beginning in 2001, the ABTS will stop publishing the names of individuals who have not recertified. Listing diplomates with invalid certificates in directories published by the ABMS has proven confusing to credentialing groups of various hospitals, managed care providers, and patients. In addition, none of the other 24 member boards of the ABMS publish in the directories the names of individuals holding invalid certificates.

All diplomates should be aware of the changes in the requirements in anticipation of renewing their own certificates. The board feels that recertification is important to the public and to each physician's professional career. All diplomates need to be up-to-date with regard to the requirements for recertification so they are prepared when the time comes to recertify.

Background

Time-limited certificates were first issued in 1976. Diplomates certified after 1975 must be recertified

ABTS recertification activity through 1999

Date of orig. cert.	Total # cert.	Total # recert 1st time	% recert	Total # recert 2nd time	% recert 2nd time
Prior to 1976	N/A	63	—	3	—
1976	160	142	89%	123	77%
1977	146	129	88	106	73
1978	154	141	92	115	75
1979	158	147	93	118	75
1980	110	100	91	65	59
1981	131	124	95	40	31
1982	159	146	92	—	0
1983	136	122	90	—	0
1984	135	125	93	—	0
1985	120	119	99	—	0
1986	147	139	95	—	0
1987	141	134	95	—	0
1988	136	126	93	—	0
1989	159	152	96	—	0
1990	122	87	71	—	—
1991	122	59	48	—	—

In 1999, 317 diplomates recertified, 187 for the first time and 130 for the second time; 254 diplomates used the SESATS computer version and 63 used the paper and pencil version.

within 10 years of the date of the original certification to maintain this status. Diplomates with time-limited certificates can apply within three years of the expiration of their 10-year certificate.

Diplomates of the Board of Thoracic Surgery and the ABTS who were certified before 1976 do not require recertification and are considered to hold unlimited certificates.

The board emphasizes the importance of recertification in communications to diplomates whose certificates are due to expire and informs them that an expired certificate is no longer valid. The board office is experiencing an increasing number of inquiries with regard to the status of diplomates of the board. The inquiries are coming from various agencies such as hospital administrations, credentials committees, health maintenance organizations, insurance companies, other third-party payors, government agencies, and those in the medicolegal professions.

Examinations

The written examination was held November 21, 1999, in Chicago, IL. A total of 164 individuals took the examination, including 135 first-time takers. The pass rate for this examination was 87 percent. The November 1999 written examination was the seventh criterion-referenced examination administered by the board. The philosophy of criterion-referenced testing is based on the concept that candidates should be measured against a standard of knowledge predetermined by the board rather than against each other, as is the case in a norm-referenced examination.

On June 9-10, 2000, in Chicago, IL, the board conducted its fourth criterion-referenced oral examination. With this type of examination, the board applies statistical methods to equate the examination. The purpose of statistical equating is to place alternative forms of the examination on a scale such that all candidates are compared to a single standard. Equating is accomplished through a statistical process that weighs each facet of an examination form. The basic premise of this analysis is that all candidates have a comparable opportunity to pass because they all are measured against the same criterion standard. In 2000, a total of 126 (85%) candidates passed the examination and 23 (15%) candidates failed it.

Applications

The time frame between the deadline for submission of an application (August 1) and the subsequent approval process has been condensed to just a few weeks since the schedule for the examination has been changed to November. Therefore, it is extremely important for all candidates to submit a complete and accurate application initially. There will be no time for corrections or additions. The board urges the program directors to help their residents in the application process by carefully reviewing each application before signing it and by informing their residents about the importance of an accurate and complete application. The board, as of its meeting in October 1999, will no longer allow residents to submit applications on August 1 pending certification by the American Board of Surgery in September. It is not administratively possible to continue to allow this extension since the time frame has been compressed by three months. Thus, the ABTS will no longer ac-

cept incomplete applications, and the August 1 deadline for submission of the application is firm for all residents.

Committee to study computer-based testing

David B. Campbell, MD, FACS, chairs a new committee, which has as its purpose the exploration of background information about computer-based testing and its possible use by the board for examinations. The board used the Internet for the administration of the in-training examination in April 2000.

Booklet of Information

The *Booklet of Information* contains information about how the operative index case requirements should be recorded and tracked, a process that now has two components: surgical volume or intensity and index case distribution. All residents must perform an average of 125 major operative cases each year with a minimum of 100 in any one year. The board application is now available electronically and is used with the CTSNet operative case log program. Information is available on the ABTS Web site: www.abts.org.

In-training examination

A total of 347 individuals participated in the 2000 in-training examination administered April 14-15, 2000. The examination consists of 80 general thoracic and 80 cardiac questions distributed among the various areas of the specialty in a manner similar to the certifying examination.

In 2000, for the first time, the examination was available in electronic format. A total of 126 candidates took it via the Internet, and 221 using paper and pencil. Score reports and comparative results were posted on the Internet for all test takers.

Examination consultants

The examination consultant committee, established in 1989, continues to be a vital component in the development of the written examination. The committee meets in September each year to review questions written by the consultants. At its meeting in 1999, 106 questions were retained for future use in the written examination.

Public education brochure

The public education brochure, "Your Surgeon is Certified by the American Board of Tho-

racic Surgery," continues to be available for purchase.

Finances

Voluntary dues payments have been eliminated. In January, an annual certification maintenance fee will be required of all active diplomates, ages 65 and under. This fee will help defray administrative expenses related to maintaining and utilizing the diplomate information on the board's computer system. The board will not respond to inquiries about the diplomate's certification status until the fee is paid each year.

Strategic planning

Several items of interest resulted from the recent strategic planning process, including:

- The board approved a motion to change the name of the recertification committee to the "maintenance of certification committee." Actions required to move from a recertification process for diplomates to one that will result in maintenance of certification and evaluation of competence will occur over a period of time.
- The board approved a motion stating that the ABTS assumes responsibility for the assessment of competency for thoracic surgeons.
- The following motion was unanimously approved:

The *ad hoc* long-range planning committee rec-

ommends that the ABTS change its current policy regarding the American Board of Surgery certification so that at some point in the future, yet to be determined, ABS certification will become optional. The ABTS will meet with other organizations involved in thoracic surgery education (Residency Review Committee for Thoracic Surgery, TSDA, AATS, STS, ACS) to discuss the significant implications of this decision.

CTSNet contract

The board approved the terms of the CTSNet contract and has become a participant on the CTSNet. The board's Internet address is: www.abts.org. Information relative to the in-training examination will be posted on this site.

New board members

At the 1999 fall board meeting, two new directors were elected: Delos M. Cosgrove III, MD, FACS, of the American Association for Thoracic Surgery, and Richard H. Feins, MD, FACS, of the Society of Thoracic Surgeons.

Marvin Pomerantz, MD, FACS, retired from the board after serving as chair during the previous two years. Dr. Crawford began his term as chair in October 2000. Peter C. Pairolero, MD, FACS, was elected vice-chair. Floyd D. Loop, MD, FACS, completed his term on the board at this meeting.

American Board of Urology

by Martin I. Resnick, MD, FACS, Cleveland, OH

The certification process of the American Board of Urology (ABU) incorporates a qualifying examination (part I) and a subsequent certifying examination (part II). To be admitted to the qualifying examination, applicants must have completed or be within six months of satisfactorily completing a urology residency program approved by the Accreditation Council for Graduate Medical Education (ACGME). To be admitted to the certifying examination, candidates must have passed the qualifying examination, have 18 months of clinical

practice experience in a single community, submit an acceptable surgical log, and receive satisfactory peer reviews.

Examinations

In June 2000, 345 candidates completed the qualifying examination, which consists of three components: an imaging examination, a pathology examination, and the qualifying examination. All three examinations are given in booklet form and are cognitive, multiple-choice examinations.

Overall, 249 (72%) passed all three examinations and 96 (28%) failed. Of the three component examinations:

- 345 sat for the imaging examination; 318 passed and 28 failed.
- 345 sat for the pathology examination; 326 passed and 19 failed.
- 334 sat for the written qualifying examination; 252 passed and 82 failed.

As has been true in other years, physicians—U.S. and international medical graduates—who had previously failed the examination had a high failure rate upon re-examination.

For the past 10 years, the pass level for the qualifying examination has been set by the criterion-reference method, equated to a previous benchmark test, using the Rasch model. The passing score will vary according to the difficulty of the examination for any year. Thus, although examinations may vary in difficulty from year to year, the probability of passing (pass rate) is based solely on the ability of the candidate pool in any given year. This is a fair and defensible methodology that does not impose an arbitrary pass/fail point.

The certifying examination currently includes examinations in urological imaging and uro-pathology as well as a standardized oral examination. The imaging and pathology examinations presently given at the certifying examination level are projected examinations. Over 2000 and 2001, the board will be transitioning to administering these examinations only in booklet form at the qualifying examination level. In the years of 2000 and 2001, these examinations will be offered at both levels until the transition is complete.

In February 2000, 337 candidates took the certifying examination; 290 (86%) passed and were certified, and 47 (14%) failed, resulting in a pass rate higher than that of recent years. The board uses a modified Rasch model for scoring the standardized oral examination. This methodology adjusts for differences in the difficulty of various protocols and in examiner severity. Consistent with the board's commitment to continually improving its evaluation processes, in 1995, the board applied a dual scoring system for the oral examination protocols. Separate grades are used for information gathering and diagnosis, and for problem solving and patient management. This has resulted in a significant increase in statistical reliability. The board

is pleased with this scoring technique for the oral examination.

The board requires completion of certification within five years of completing an ACGME-approved residency program; extensions are granted for approved fellowship training. Failure to complete certification within the time allotted requires reentry into the certification process at the qualifying examination level after passing a preliminary examination.

Recertification

In 1992, the board began its mandatory recertification process for all diplomates with 10-year time-limited certificates, which have been issued since 1985. Currently, all trustees of the ABU recertify during their tenure on the board. The process consists of multiple components. These various components provide the diplomate with different opportunities and ways to document his or her competence. A modular, written, open-book examination consists of five subject areas from which the diplomate will choose three with which he or she is most comfortable. Each module has 20 questions, for an individual examination of 60 questions. Other components include peer review, a surgical log review, and a continuing medical education requirement. In addition, at the board's discretion, hospital/office chart reviews, an oral interview or examination, and/or a site visit may be required. Diplomates may enter the recertification process up to three years before expiration of the primary certificate. Upon successful recertification, the diplomate is issued a certificate valid for 10 years from the date of expiration of the original certificate. In November 1999, 233 diplomates sat for recertification, and 226 (96.9%) successfully completed the recertification process.

Officers and trustees

Current officers are: Andrew C. Novick, MD, FACS, president; John M. Barry, MD, president-elect; Thomas J. Rohner, MD, FACS, vice-president; and Martin I. Resnick, MD, FACS, secretary-treasurer. Current trustees are: Michael J. Droller, MD, FACS; Robert C. Flanigan, MD, FACS; Fray F. Marshall, MD, FACS; Mani Menon, MD, FACS; Michael E. Mitchell, MD, FACS; Dr. Paul F. Schellhammer, MD, FACS; Joseph A. Smith, Jr., MD, FACS; and Robert M. Weiss, MD, FACS. □

Keeping current

Scientific American® Surgery: A conversation with the founding editor

Editor's note: Douglas Wilmore, MD, FACS, is the Frank Sawyer Professor of Surgery at Harvard Medical School and founding editor and editorial chair of *Scientific American® Surgery*. With the support of the American College of Surgeons and his editorial board members (see sidebar, p. 44), Dr. Wilmore inspired the evolution of *Scientific American Surgery* from a premier surgical reference book to a unique online resource available exclusively on WebMD's physician Web site: www.webmd.com (<http://www.webmd.com>).

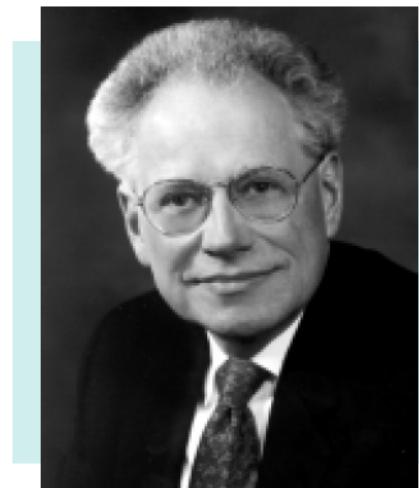
In this interview, Dr. Wilmore provides background information on *Scientific American Surgery*, including a brief history, an overview of online features, as well as insights on the benefits of integrating Web-based resources into your daily practice.

Q. What was the original publication concept for *Scientific American Surgery*?

A. The American College of Surgeons has long provided surgical manuals to its membership, and these publications served as the foundation for *Scientific American Surgery*. From about 1960 until the late 1970s, the ACS published a variety of surgical manuals that covered specific areas, including trauma, infection, nutrition, and perioperative care. Publication later slowed, and in the early 1980s, the pre- and postoperative care committee considered revitalizing the manuals. It was at this time that we began to think about these texts in broader terms—that is, of incorporating them into one complete surgical reference that could be updated regularly.

Q. How did this original concept lead to the vision of *Scientific American Surgery* online?

A. By the mid-1990s, we recognized that integrating electronic methods was the next logical step for *Scientific American Surgery*. We eventually moved the publication to the CD-ROM for-



Dr. Wilmore

mat, which was effective for those who were open to the technology and willing to explore beyond the printed text. Once WebMD acquired *Scientific American Surgery*, however, we finally achieved the technical know-how and support to upgrade and offer the complete online version, now published by WebMD and hosted exclusively on its physician site.

Overall, I would say that the most important factor that contributed to *Scientific American Surgery* online is the fact that the original publication was organized to be formatted for the computer and to be time-sensitive. For the purpose of quick reference and accessibility, the printed text was carefully constructed so that the concepts a practicing surgeon would need to know right away were placed at the beginning of the text. This attention to continuity and to the prioritizing of information during the initial development of *Scientific American Surgery* proved to be a great benefit, as the printed text could be adapted easily in electronic form.

Q. How do you see *Scientific American Surgery* relating with other WebMD content to create an information tool for surgeons?

A. The WebMD advantage has provided *Scientific American Surgery* with the ability to move from a static text to a more dynamic, interactive, and instantly available resource. It is a powerful information tool in that it allows you not only to retrieve medical information from *Scientific American Surgery*, but to immediately review cited references and explore related practice content on WebMD as well. The surgical information and features offered on WebMD's physician site greatly enhances the content found in *Scientific American Surgery*, and vice versa. This is a highly unique resource, and nowhere else on the Web can you find authoritative surgical information in one complete product. There are online resources available that may offer specific clinical services or bits and pieces of medical content, but the WebMD and *Scientific American Surgery* connection supplies a one-stop, comprehensive resource that surgeons can integrate into their daily practice.

Q. How does *Scientific American Surgery* address the information needs of practicing surgeons and trainees?

A. Together with WebMD, we have formed a real core of information for practicing surgeons and those in training by providing immediate access to the newest and latest in surgical protocols, recommendations, and techniques. It is an invaluable resource that is continuously updated, easy to use, and accessible at any time. The complete version of *Scientific American Surgery* is readily available on WebMD's physician site, including all content, practice algorithms, and updates that are found in the printed version.

Q. What are some key features of *Scientific American Surgery* online?

A. For the busy surgeon, some of the most beneficial features of the site include interactive treatment algorithms; references hot-linked to MEDLINE, which offers printable abstracts; continuing medical education; and, in the future, ad-

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vanced search functions. The online version also offers detailed figures and illustrations that you can easily click onto and download. Each image is accompanied by explanatory text—which can be very useful for lectures and presentations and for providing information for patients. In addition, a link to “What’s New in Surgery” is available, including a summarized update of new content and features.

Q. What are some hurdles that surgeons may face when using the Internet?

A. Like any new technology, the user must become adept at the methodology. Today, we find that younger surgeons have grown up using computers and do not view them as barriers when searching for and retrieving information, whereas older surgeons are frequently taught Internet skills by their children or learn from their younger peers. Technical knowledge and its application to practice appear to vary with each generation of surgeons, yet all are learning something new every day. Another important issue is that the content found on the Internet has not always been user-friendly, and the busy physician may find it more time-consuming to use the Internet to access information than to locate the information in a textbook. Efforts are under way, however, to facilitate easier access and retrieval of information on the Internet. In fact, it was critical for us to establish *Scientific American Surgery* online as a fast and easily accessible resource, and we will continue to advance this aspect of the site as we expand our content and features.

Q. Who is accessing *Scientific American Surgery* online?

A. Currently there are more than 30,000 ACS Fellows, Associate Fellows, and Candidates enrolled in the part of WebMD’s site that is devoted exclusively to physicians. There is strong international interest, and we are finding that many medical institutions are adopting *Scientific American Surgery* (and *Scientific American Medicine*) as their primary resource for medical information. In fact, I think it is a tremendous benefit that the ACS membership has been provided with subsidized subscriptions to WebMD. Now our members

have the opportunity to easily access *Scientific American Surgery* online and discover a readily available resource that they can incorporate into everyday practice.

Q. What new developments can we expect from *Scientific American Surgery* online?

A. I am very interested in fostering greater interactivity within various aspects of *Scientific American Surgery* online. For example, we would like to offer the opportunity for live discussion or online chats with experts in various areas of surgical practice. Also, our long-term goal is to create a “cafeteria-style” selection of content and features. Through this concept, I would like surgeons to eventually be able to pick and choose information based on their particular interests and practice needs. Essentially, we would like to provide personalized content for each individual physician. I also see a great need to translate information so that it is helpful to our patients. Today, patients are eager to learn more about the impact and effects of their surgical procedures, and I am hoping that we will be able to provide helpful patient education materials through *Scientific American Surgery* online. Such materials might include anatomical drawings and even the opportunity for patients to participate in live presentations about operations and discussions with surgeons and other patient advocates. ☐

Socioeconomic tips of the month

Reporting an altered surgical field, modifier -60

A new modifier for reporting an altered surgical field, modifier -60, was included in the 2001 version of the *Current Procedural Terminology* (CPT) manual. However, Medicare and perhaps some other payors are not recognizing this new modifier. The "CPT Changes in 2001" article in the January issue of the *Bulletin* provided a brief summary of the purposes of the new modifier and how to use it. This article provides more recent and detailed information.

CPT 2001

Modifier -60, altered surgical field, is intended for use when a surgical procedure involves significantly increased operative complexity and/or time in a field that has been altered by the effects of prior surgery (including marked scarring or adhesions), inflammation or infection, distorted anatomy, irradiation, very low patient weight (that is, neonates and infants less than 10 kg) and/or trauma. In addition, the language for modifier -22, unusual procedural services, has been revised to indicate that services involving an altered surgical field should be reported using modifier -60 instead of modifier -22.

Reporting to Medicare

The Health Care Financing Administration (HCFA) has issued an instruction telling carriers not to recognize modifier -60 for payment purposes. The instruction indicates that surgeons are to continue to report surgical procedures that involve significantly more complexity and/or time due to an altered surgical field using modifier -22, unusual procedural services. Medicare carriers are instructed to continue using existing, pre-2001 policies and procedures with respect to modifier -22 to determine reimbursement. Medicare secondary payors also will accept modifier -22.

Generally, Medicare carriers require two pieces

of additional documentation when modifier -22 is used. The first is a special report from the surgeon requesting additional reimbursement and summarizing in one or two paragraphs why the service or procedure was unusual and the work substantially greater than usual; the second is a copy of the operative report. Please refer to "Socioeconomic tips of the month" in the June 2000 *Bulletin* for a more detailed discussion of reporting modifier -22.

Surgeons and their billing staffs should read the article in their local Medicare carrier bulletin on this departure from CPT's intended use, especially because there may be some local carrier information that is of interest. It is possible that local carriers published this information earlier this year.

Reporting to other payors

Payors that do not recognize many modifiers probably will not recognize modifier -60. On the other hand, some payors want to comply with CPT rules and will develop policies regarding modifier -60. However, as with the -22 modifier, surgeons should not routinely use modifier -60. As the CPT definition says, modifier -60 should be appended only when the procedure involves "significantly increased operative complexity and/or time in a significantly altered surgical field," so be sure the standard for "significantly" is met. Also, there are some specific instances in which the use of the modifier is inappropriate. For example, the modifier should not be reported (or should be reported very infrequently) if the code already has the modifier "built in" (that is, the code is for a reoperation or the code is used specifically for neonates or infants weighing less than 10 kg). Finally, do not be surprised if payors request documentation, much as they do for modifier -22, unusual procedural services.

What happened

Many surgeons believed there would be more uniform recognition of additional work in an al-

continued on page 55

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College news

Faculty Research Fellowships awarded by College

Ten American College of Surgeons Faculty Research Fellowships for 2001 were awarded by the Board of Regents in February. The two-year fellowships are offered to surgeons entering academic careers in surgery or a surgical specialty and carry grants of \$40,000 per year from July 1, 2001, through June 30, 2003. The recipients are as follows:

Kevin Staveley-O'Carroll, MD, PhD, assistant professor, Penn State College of Medicine, Hershey, PA. Research project: Breaking tumor-antigen-specific, CD8+ T-cell tolerance. Dr. Staveley-O'Carroll's fellowship—the Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the American College of Surgeons—is named to honor Dr. Martin, founder of the College, and is funded by the Scholarship Endowment Fund of the College.

Marc H. Hedrick, MD, assistant professor, UCLA School of Medicine, Los Angeles, CA. Research project: Engineering bone from human adipose-derived stem cells (ADSCs). The fellowship is funded by the Scholarship Endowment Fund of the College.

Anne C. Fischer, MD, PhD, assistant professor, Johns Hopkins School of Medicine, Baltimore, MD. Research project: The role of T lymphocytes on hepatic regeneration. The fellowship is sponsored by the Scholarship Endowment



Dr. Staveley-O'Carroll



Dr. Hedrick



Dr. Fischer



Dr. Clary

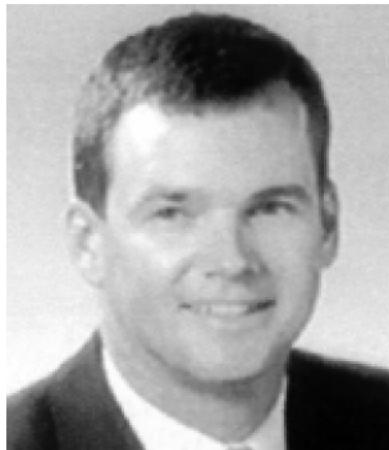
Fund of the College.

Bryan M. Clary, MD, assistant professor, Duke University Medical Center, Durham, NC. Research project: In vivo pro-

duction of endostatin following anti-angiogenic retroviral gene therapy in the treatment of metastatic colorectal cancer. The fellowship is sponsored by



Dr. Naughton



Dr. Hughes



Dr. Parangi



Dr. Kahlenberg



Dr. Johnson



Dr. Lee

the Scholarship Endowment Fund of the College.

Cathy K. Naughton, MD, assistant professor, Washington University School of Medicine, St. Louis, MO. Research project: The role of GDNF and related receptors on mouse testicular development and their impact on human infertility and testicular

tumors. The fellowship is sponsored by the Scholarship Endowment Fund of the College.

Steven J. Hughes, MD, assistant professor, University of Pittsburgh, Pittsburgh, PA. Research project: The trafficking and function of Fas (CD95) protein in esophageal adenocarcinoma. The fellowship is spon-

sored by the Scholarship Endowment Fund of the College.

Sareh Parangi, MD, instructor in surgery, Harvard Medical School/Beth Israel Deaconess Medical Center, Boston, MA. Research project: Antangiogenic gene therapy, a novel therapy for pancreatic cancer. The fellowship is sponsored by

the Scholarship Endowment Fund of the College.

Morton S. Kahlenberg, MD, assistant professor, University of Texas Health Science Center, San Antonio, TX. Research project: Cellular compensatory pathways in response to Her-2-Neu inhibition in colorectal cancer: A new treatment paradigm. The fellowship is sponsored by the Scholarship Endowment Fund of the College.

Jeffrey L. Johnson, MD, attending surgeon, Denver Health Medical Center/University of Colorado, Denver, CO.

Research project: The role of gene polymorphisms in postinjury hyperinflammation and multiple organ failure. The fellowship is sponsored by the Scholarship Endowment Fund of the College.

Cheryl T. Lee, MD, assistant professor, University of Michigan, Ann Arbor, MI. Research project: A Phase I/II trial assessing intratumoral administration of dendritic cells activated by GM-CSF and IL-4 as a tumor vaccine in bladder cancer. The fellowship is sponsored by the Scholar-

ship Endowment Fund of the College.

The Scholarship Endowment Fund of the American College of Surgeons was established in 1965 to provide income to fund scholarships and fellowships awarded by the Board of Regents. Fellows who are interested in making gifts to fund these vital programs are encouraged to contact the Development Office at 312/202-5376. Further information regarding the ACS Faculty Research Fellowships is available on the College's Web site, www.facs.org.

Wyeth-Ayerst to sponsor ACS scholarship

Wyeth-Ayerst Pharmaceuticals of Philadelphia, PA, will sponsor one of the ACS Resident Research Scholarships for 2002-2004. The purpose of the scholarship is to provide two

years of laboratory experience to residents performing surgical research related to biological and physiological aspects of inflammation.

The requirements for the ACS

Residency Research Scholarships appeared in the January 2001 issue of the *Bulletin* (p. 43), and are also posted on the College's Web site, www.facs.org.

GOVERNORS' COMMITTEE, from page 30

the age limit or are in retired status.

The Fellowship Liaison Committee expressed concern to the Fiscal Affairs Committee about the dues and fees assessed on Associate Fellows. The committee understood their concern, especially with regard to new Associate Fellows. The committee and the Board of Governors as a whole recommended a dues decrease for Associate Fellows to the Finance Committee and the Board of Regents. However, the Finance Committee and the Board of Regents felt that it might be premature to alter the dues structure while the College is in the midst of strategic planning. Therefore, the Finance Committee approved an alternative to a dues reduction—specifically, a reduction in dues for the

first year. Associate Fellows will be charged a first-year application fee of \$75 versus annual dues of \$188. This alternative was approved by the Board of Regents.

Conclusion

It has been a pleasure working with the committee this year, and I would like to thank each of the committee members for their excellent efforts. With equal enthusiasm I have appreciated the help of College staff: Fred Holzrichter; Jack Lynch, Director of the College's Organization Department; Gay Vincent, Comptroller; Keith Bura of the Accounting Department; and Lynese Kelley of the Office of the Comptroller. Ω



Letters...

The following comments were received via e-mail regarding the "From my perspective" column written by ACS Executive Director Thomas R. Russell, MD, FACS, and published in the December 2000 issue of the Bulletin. The column focused on the current debate regarding residency work hours (see www.facs.org/fellows_info/bulletin/dec00bullet.html).

Con

I am a former Governor of the College, medical school associate dean, department chair, and gynecologic oncologist who was Missouri's Outstanding Young Surgeon a long time ago. I inspected a residency a number of years ago in New York and found it totally lacking in any educational merit and the service was entirely run by residents who were overwhelmed with work and never out of the hospital. The general public is appalled with the lack of sensitivity of medical leadership on this issue. I'm sure polls will show great public support for limiting the time residents spend at work and little sympathy for surgeons and hospitals who need cheap help.

We should get on the right side of this issue. Medicine is being seen, more and more, like the British Generals of the Second World War—out of touch with the common soldier. We are out of touch with our patients and the young people who we hope will enter medicine. It is particularly interesting to remember that the hospitals in New York received several hundred mil-

lion dollars to cut the number of residencies just a few years ago. They can afford the ancillary people to limit the surgical resident to tasks requiring a physician. I, like you, I'm sure, worked on 36 and off 12 for years at a time. I do not think it produces a better doctor, person, parent, marital partner, personality, state of mental and physical health, or citizen. We must be seen as more than a guild if we are to represent the public interest.

**Byron J. Masterson,
MD, FACS**

With respect to restriction of work hours for residents, while I agree with you that arbitrary imposition of time off after long periods of duty may not be optimal for education or patient safety, some standards need to be in place to protect both the resident and the patient. I think you must know that there is a wide spectrum of endurance among human beings. Some can run marathons and others can barely walk to the refrigerator for another beer. We both know that one of the things that residency training teaches is that each person's endurance capacity is larger at the end than at the beginning and larger than each person suspects at the beginning. But the maximum endurance of each individual is quite variable. The schedules imposed on many if not most individuals in residency training are probably based on the capacity of the most fit, not the least fit, and probably not even the average resident.

If we cannot educate residents in the years allotted because of

restriction of hours, the answer is not to make them work more hours during a given year. The answer is to extend the length of time allotted or do a better job during the time spent.

Fresh minds learn a lot. Tired minds learn little. Let's keep that in the front of our minds when we call ourselves educators. Let's take on the challenge of getting lots of knowledge into those fresh minds and refreshing them optimally. Let's look at training from the point of view of how much can I get into this fresh mind in the restricted hours I have to teach it, instead of the assuming that the resident is around 24 hours a day to do my bidding and that he ought to learn something from the experience. When we do so, we won't have any problem working within the statutory guidelines set down in New York. And maybe we'll produce more humane, less egotistical surgeons in the process.

**Stephen Goldberger,
MD, FACS**

Your editorial on residency hours was thought-provoking. The reference to the College's official statements showed that in fact the College is at least six or seven years out of date. The economic realities of surgical practice mandate that fundamental changes be made in the education of residents. The training intervals need to be truncated with earlier sub-specialization. The question is why a cardiac/plastic/transplant/vascular...surgeon needs to spend all those years doing types of surgery that they will never do so again in their career.

LETTERS, continued

I agree that the stamina to be a surgeon is very different from other medical specialties; therefore the specific weekly hour requirements are irrelevant. The College can support this. At the same time, address the abuse of residents by academic centers using residents as cheap labor on complex services that they will never use. This would represent a bold move on the part of the College. I will not hold my breath.

John Long, MD, FACS

I must respectfully disagree with many of your comments. To your remark that "constrained work hours do not prepare residents for the real world of surgical practice" I'd respond: Then that's a problem with "the real world of surgical practice." Benefit would be gained from changing that reality.

Though the New York legislation is "arbitrary" it is certainly not unreasonable. The legislature is rightly concerned that citizens cared for by a resident who has gone without sleep for 24 hours are at increased risk of a variety of errors. I'm surprised that you should comment that "no study has established a relationship between resident work hours and diminished care," when there must be numerous studies linking fatigue with errors. To ignore such studies because they were performed by the military or other industries is to oversimplify the picture.

I also find it ironic that later in your article you comment that residents should spend their time on "matters of clinical importance.... Little or no time

should be spent on such matters as...doing excessive paperwork and other administrative tasks." Now that would be a program that fails to prepare residents for "the real world of surgical practice."

I do agree that "work hours during residency training should be much more than simply logging time in the hospital." But I believe that there is reasonable fear that residents are at times unsafe due to excessive fatigue. If we can't properly define an adequately rested clinician, how can we complain when the legislative process imposes their best-guess solution?

**Greg D'Augustine,
MD, FACS**

Pro

Dr. Russell:

Your recent commentary on resident work hours was right on target. That "constrained work hours do not prepare residents for the real world of surgical practice" is certainly true and could be generalized to many if not all medical specialties—constrained work hours during training do not prepare residents for the real world. A recent graduate of our general surgery residency joined a large group practice and told me that although he was working hard in his new job he was pleased not to be putting in as many hours as during his residency. He favorably compared his situation with medical specialist colleagues who were working almost as many hours as him but longer hours than during their training. He was

happy; they weren't. I don't envy your job of trying to influence the many regulators and decision makers of policies that impact on surgeons and surgery. I am grateful that someone with your insight and talent is our advocate.

Dan Ledbetter, MD, FACS

My idea of a professional is one who takes the responsibility of seeing that a problem is solved or that a task is accomplished as best as can be done, regardless of the time and effort required, and who has the necessary knowledge and skill. A craftsman, to me, is one who possesses skill and knowledge in a particular area of expertise. Given these definitions, into which group does the surgeon belong? Can one be a surgeon and "punch the clock"? Some medical specialties (such as radiologists) work in shifts. Should we? You can think of some nice scenarios for that. Perhaps our military can adhere to the same constraints should we be so unfortunate as to have a war.

A. D. Smith, MD

Your perspective on resident work hours is right on! The issue involved is one of patient responsibility. If a surgical resident in his or her senior year carries out major operative procedures, it should be his responsibility to follow that patient and administer the same type of appropriate care as would be delivered by a surgeon in private practice.

What legislation like that in New York is suggesting is that after a surgeon in practice com-

LETTERS, continued

pletes a long and difficult operation, he/she should turn over care to someone else. Should a surgeon be up all night on emergency and trauma call, he should abandon his patients the next day.

As you well know, the surgeon in practice who carries out a major procedure and then says to his or her patient, "Bye, I have a date to go skiing," will not have many patients when word gets around regarding how he handles his practice.

**F. William Blaisdell,
MD, FACS**

I fully agree with your conclusion concerning residency training. However, I don't understand why there is doubt about the proper and appropriate environment that needs to be created. That environment is the patient in the hospital and in the outpatient clinics with the *sole* focus on the evaluation, diagnosis, and treatment of their *medical* needs by residents in a program of graded progressive responsibility.

The scheduled responsibility at G.M.H. in Atlanta was 36 hours on duty and 12 hours off duty, with the exception of the emergency clinic rotation that required 24 hours on duty and 24 hours off duty. Any extra time off was negotiated between residents for weekends and holidays. I do not recall any "stressed out" residents and we were in a pyramid system. Another aspect of the environment: I never heard one word about the "business to the practice of medicine." In many regards our present unhealthy state of residency training is due to the ex-

ploitation of residents for non-medical duties (medical as described previously) and to the lack of vigilance and foresight of the Committee on Residency Training.

S. Angier Wills, MD, FACS

I wholeheartedly agree with your thoughts expressed in the "From my perspective" article in the December 2000 *Bulletin*. Restricting residents' work hours would do a great deal of damage to the training programs as well as to patient care. Residents are not truckers and their presence in the institution is essential for their learning process.

S. Jim Farha, MD, FACS

I read your article with keen interest, and I agree with your perspective. These constrained work hours and the limitations imposed by the Residency Review Committee have entitled certain residents to leave their clinical duties unresolved. As a chief resident in plastic surgery last year, I had interns who refused to round with me on Saturday or Sunday because it was their "day off," and so I ended up performing intern duties as a chief in order to take care of my patients. I think these limitations have undermined the teamwork required in residency, especially for those who think they are entitled to anything. I appreciate your article.

Mark F. Price, MD

I am a past Governor of the College and Past-President of the Argentine Chapter. As chairman at a university hospital, I trained many generations of

general surgeons. I also serve as an advisor to the navy for the training of their residents.

One of the principles I always admired in the United States is that the government never interfered with academic activities. And now I see they presume to regulate the working hours of surgical residents, surely against the desire of residents and directors of residency programs. Some bureaucrats will never understand that surgical residents need to operate and see as many patients as possible in a fixed period of time. With the decrease of many diseases that years ago were surgical cases—such as peptic ulcers or "watchful waiting" in hernias, plus the increase of endovascular procedures and endoscopic surgery—it will be more and more difficult to have enough patients for proper training. The situation will be much worse if residents are forced to stay at home because of state regulations.

In Argentina, we imported managed care and the need for professional liability committees. I hope you will be able to continue your task and I share your concerns.

**Vicente P. Gutierrez,
MD, FACS**

ACS joins public health initiative to reduce firearms-related injuries

The American College of Surgeons has joined a dozen national medical and surgical specialty societies in a coordinated effort to bring a public health perspective to developing strategies for reducing the number of firearm-related injuries. Doctors Against Handgun Injury, or DAHI, is not a gun control organization. The group has no intention of interfering with the right of lawful citizens to own firearms. Rather, the coalition was formed to promote policies that rely on education, data collection, and evidence-based interventions to address this major public health problem that now claims more lives each year than motor vehicle crashes.

More specifically, DAHI is committed to pursuing initiatives to prevent injury by:

- Educating patients about the dangers posed by the improper use and storage of firearms.
- Improving our knowledge about how and why firearm injuries occur by developing a national database.
- Treating firearms like other consumer products for purposes of evaluating and improving their safety.
- Prohibiting practices that are known to divert firearms from the legal market, making them more accessible to unauthorized people.
- Applying current firearm

sale and distribution requirements consistently.

- Supporting aggressive enforcement of current laws pertaining to the misuse of firearms.

Taking a public health approach to injury control and prevention has been tremendously effective in reducing the number of Americans killed or severely injured by motor vehicles, bicycles, fires, and other devices and forces. As an organization that is committed to the care of severely injured patients, the College intends to work with DAHI so that the same approach is applied to reduce the enormous toll that is imposed on our society by firearm-related injuries.

Coding workshops

The College will be hosting coding workshops for the first half of 2001. We have a new one-day format, for all surgeons, with a new consultant. The program, Coding and Documentation: The Keys to Reimbursement, will present both CPT and ICD-9-CM coding for surgeons and their office staff that is basic to intermediate. The program will include an interactive networking lunch to assist in meeting other colleagues with similar coding issues. Earn eight Category I CME credit hours.

Dates and locations:

April 28, 2001	Pointe Hilton at Squaw Peak, Phoenix, AZ
May 10, 2001	Sinclair Community College, Dayton, OH (program in conjunction with the May 10-12 Ohio Chapter meeting)
May 27, 2001	Hilton San Francisco, CA
June 9, 2001	Caribe Hilton, San Juan, PR
June 22, 2001	ACS Headquarters, Chicago, IL
June 23, 2001	Lake Lawn Resort, Delavan, WI

For further registration information, contact Diane Mazmanian at 312/202-5406; fax: 312/202-5021; e-mail dmazmanian@facs.org.

Chapter news

by Rhonda Peebles, Chapter Services Manager, Organization Department

To report your chapter's news, contact Rhonda Peebles toll-free at 888/857-7545, or via e-mail at rpeebles@facs.org.

Manitoba Chapter holds competition for residents

Last November, the Manitoba Chapter conducted a basic and clinical sciences competition for surgical residents. More than 20 papers were presented, and the following residents received awards:

- First prize—research: D. Ewing-Bui, MD.*
- Second prize—research: M. Moon, MD.
- First prize—clinical: Dion Davidson, MD.
- Second prize—clinical: B. Zabolonty, MD.
- First case presentation: M. Wowk-Litwin, MD.
- Second case presentation: Rohit Singal, MD.

Lebanon Chapter hosts recognition dinner

The Lebanon Chapter held a special social event at the Phoenicia Hotel last November to recognize Fellows who have served in leadership capacities in the past. These Fellows included Robert Chaiban, MD, FACS; Kamal Hamadeh, MD, FACS; Albert Haykal, MD, FACS; and Antoine Lattouf, MD, FACS. Chahine Abousleiman, MD, FACS, the current Chapter President, presided over the special ceremony and encouraged the 10 newest Fellows in Lebanon to participate in the chapter's activities and education programs.

Joint meeting in Nassau County, NY

The Brooklyn-Long Island Chapter (BLIC) and the Nassau Surgical Society conducted their first joint meeting on December 6, 2000, at the Marriott Hotel in Uniondale, NY. In addition to all-day and half-day specialty presentations, Thomas R. Russell, MD, FACS, the College's Executive Director, presented the keynote address. The College provided continuing medical education credit



Dr. Abousleiman (center) presented the Lebanon Chapter Shield to Dr. Lattouf, a former Chapter Officer; Ramzi Finan, MD, FACS, Secretary, observes the presentation.

hours for the joint education program, which nearly 400 Fellows and residents attended. Saquib Chaudhry, MD, FACS, Chapter President, served as the coordinator for the BLIC.

New Surgeons Survival Manual available on CD-ROM

The Ohio Chapter has revised and released its very popular *New Surgeons Survival Manual* on CD-ROM. Originally published about six years ago, the manual has been updated every year. With nearly 200 pages, the new manual contains information on setting up a practice in Ohio, contact information for all the insurance carriers that serve Ohio, as well as a comprehensive listing of the medical and specialty societies in the state. Since the Ohio Chapter introduced this publication, five chapters have published similar material online: Arizona, Indiana, Missouri, New Hampshire, and Eastern Pennsylvania. To obtain a copy of the Ohio Chapter's new CD-ROM, please call Jane Treiber, Executive Direc-

*Denotes participant in the Candidate Group.

tor, at 937/586-3717, or write to her at jane_treiber@mei.meinet.com. (Note: To view the chapters' online versions of their "survival manuals," visit the chapter Web sites at http://www.facs.org/fellows_info/acs_chapters/acschapt.html.)

France Chapter honors Professor Murat

The France Chapter has named John R. Murat, MD, FACS, Honorary Governor of the France Chapter; Dr. Murat previously served as the Governor of the chapter. This recognition was extended to Dr. Murat for his longtime contributions to the France Chapter; he was a founding member, and he served as President and Secretary-Treasurer as well. In April 2001, the chapter will conduct its first Spring Meeting, which will focus on colon and rectal cancer and laparoscopy.

Louisiana Chapter conducts 49th annual meeting

The Louisiana Chapter conducted its 49th annual meeting on January 20-21 in New Orleans, LA, in conjunction with the Surgical Association of Louisiana (SAL). Barry Landry, MD, FACS, SAL President, opened the educational program with a report on his volunteer surgery activities in South

America. He reported that his mission was a "life-changing" event, and he encouraged other Fellows to participate in these types of surgical missions. The program featured presentations by five visiting professors: Timothy Flynn, MD, FACS, Gainesville, FL; John S. Najarian, MD, FACS, Minneapolis, MN; Ronald Maier, MD, FACS, Seattle, WA; Phillip Caushaj, MD, FACS, Pittsburgh, PA; and David Herndon, MD, FACS, Galveston, TX. In addition, at the annual business meeting, J. Patrick O'Leary, MD, FACS, Chapter President, presented the M. L. Jarrell Traveling Resident Fellowship Award to Cheryl Ann Stanski, MD*, a resident at Tulane University in New Orleans, LA.

Chapter anniversaries

Month	Chapter	Years
March	Brazil	49
	Southern California	49
	Massachusetts	36
	Nevada	36
	New Hampshire	49
	Puerto Rico	51
April	South Dakota	49
	Metropolitan Chicago	46
	Mississippi	48
	Oklahoma	51

*Denotes participant in the Candidate Group.

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tered surgical field if they separated the operations having an altered surgical field from other surgical and nonsurgical services having the -22 modifier. Physicians felt that payors could more easily work out policies to govern use of the new modifier because it would not apply to as many codes. HCFA decided not to recognize the new modifier at all because of the agency's fear that the number of claims with the new modifier would increase, causing the number of claims requiring manual review to rise. However, HCFA did not voice these concerns publicly until after the 2001 edition of CPT had been "put to bed."

It appears that for 2001, the situation will be very confusing, with some payors instructing surgeons

to follow CPT 2001 guidelines and some payors instructing surgeons to follow CPT 2000 guidelines. The College and the CPT editorial panel are concerned about the situation and are working to have a single reporting mechanism in place for 2002. Ω

This column responds to questions from the Fellows and their staffs, and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site for easy retrieval and future access. If there are topics that you would like to see addressed in future columns, please contact the Chicago staff of the Health Policy and Advocacy Department, tel. 312/202-5150; fax 312/202-5021; or e-mail HealthPolicyAdvocacy@facs.org.

The *Journal* page

Message from the Editor

by Seymour I. Schwartz, MD, FACS, Rochester, NY

The American College of Surgeons has "education" built into its genetic code because it evolved from Clinical Congresses and a monthly journal. That monthly journal—now the *Journal of the American College of Surgeons* (*JACS*)—has entered a new phase as an educational modality with the incorporation of a Web-based interactive program providing continuing medical education (CME)-1 credits (www.jacscme.org).

In this electronic age, it is possible to structure a Web site that is both user friendly and educationally satisfying. As a novitiate in the realm of the computer and Web use, I can attest to the ease of the *JACS* CME process. The educational satisfaction stems from the fact that as the participant courses through the program, the issues defined in the selected article are reinforced.

The CME on the *JACS* Web site is unlike that incorporated in other surgery journals, because

knowledge acquired by reading the article is truly tested, and the correct interpretation is emphasized by a critique. Thus, each step in the process is educational.

The expenditure of a modest effort by the participant each month can provide 24 level 1 CME credits each year on the Web site. The staff of *JACS* has a great sense of pride in bringing this new, attractive, and enriching product to you. It is emblematic of the recent dramatic changes that have taken place with *JACS*, which has become a membership benefit of the College.

Dr. Schwartz is Distinguished Alumni Professor, University of Rochester (NY) School of Medicine and Dentistry. He is also Editor-in-Chief of the *Journal of the American College of Surgeons* and a Past-President of the College.

INTRODUCTORY ABSTRACT from the May lead article

Mathematical Modeling to Define Optimum Operating Room Staffing Needs for Trauma Centers. Charles E. Lucas, MD, FACS, Kennan J. Buechter, MD, FACS, Robert L. Coscia, MD, James M. Hurst, MD, FACS, John W. Meredith, MD, FACS, John D. Middleton, MD, FACS, Charles R. Rinker, MD, David Tuggle, MD, FACS, Angie L. Vlahos, MS, Jack Wilberger, MD, FACS. From the department of surgery, Wayne State University, Detroit, MI.

Background: Level II trauma centers (TCs) may be verified with an on-call operating room team if the performance improvement program shows no adverse outcomes. Using queuing and simulation methodology, this study attempted to add a volume guideline.

Methods: Data from 72 previously verified TCs identified multiple demographic factors including specific information regarding the first trauma-related operation done between 11:00 pm and 7:00 am each month for 12 consecutive months.

Results: The annual admissions averaged 1,477 for 37 Level I TCs, 802 for 28 Level II TCs, 481 for 4 Level III TCs, and 731 for 3 pediatric TCs. The annual admissions correlated with the number of operations done from 11:00 pm to 7:00 am ($p<0.001$). These 946 operations were performed by general surgery (39%), neurosurgery (8%), orthopaedic surgery (33%), another specialty (9%), or multiple services (9%). Admission to operation time was within 30 minutes in 12.1% of patients (2.6% for blunt injuries and 24.1% for penetrating injuries). The probability of operation within 30 minutes of arrival varies with number of admissions and the percent of penetrating versus blunt injuries. The likely number of operations from 11:00 pm to 7:00 am would be 19 for 500 annual admissions, 26 for 750 annual admissions, and 34 for 1,000 annual admissions with 5.83, 7.98, and 10.13 respectively, going to the OR within 30 minutes. The probability that two rooms would be occupied simultaneously is 0.14 and 0.24 for centers admitting 500 and 1,000 patients, respectively.

Conclusion: Trauma centers performing less than six operations per year between 11:00 pm and 7:00 am could conserve resources by using an immediately available on-call team with responses monitored by the performance improvement program.